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West Virginia Medical JOURNAL

Volume 92 No. 1 West Virginia State Medical Association January/February 1996

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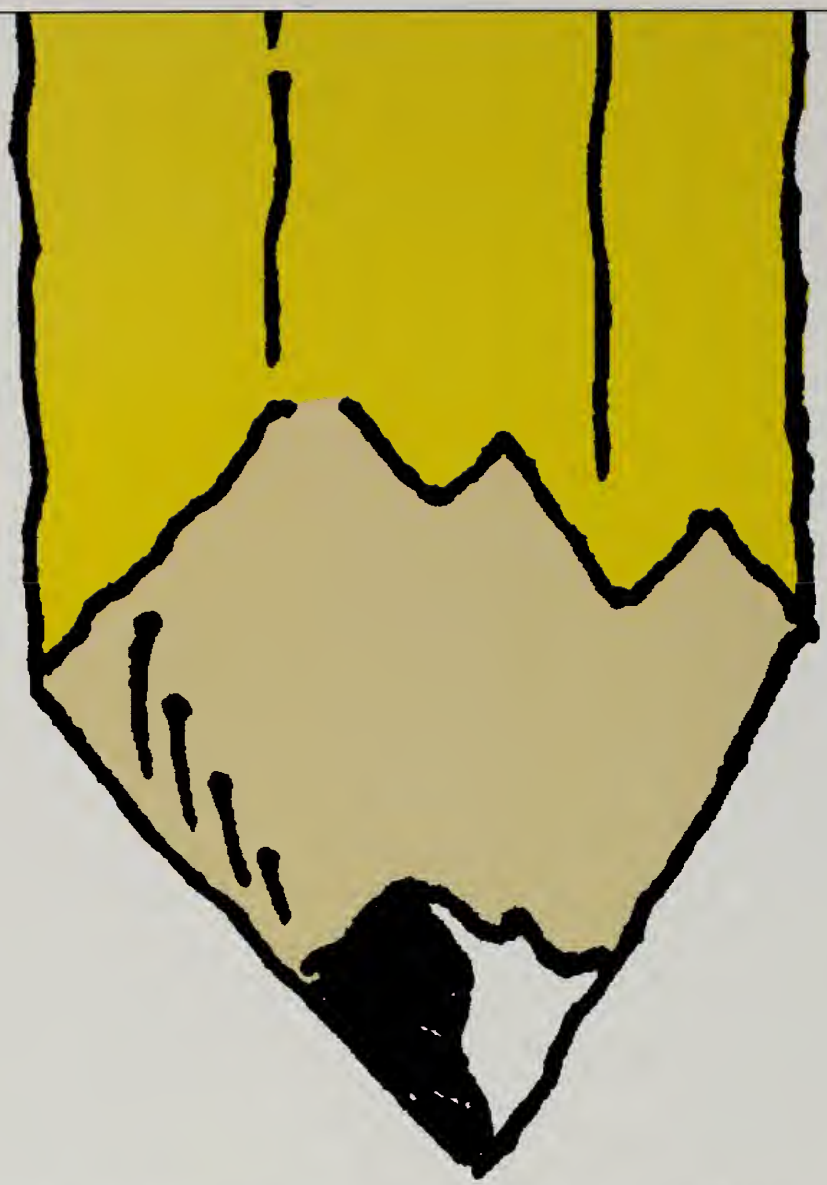

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WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published bimonthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on the condition that they are contributed solely to the *West Virginia Medical Journal.*

The views expressed in the *West Virginia Medical Journal* are those of the individual authors and do not necessarily reflect the policies or opinions of the *West Virginia Medical Journal,* its editor, associate editors or staff, or the West Virginia State Medical Association and its staff. Publication of advertisements is not to be deemed an endorsement of any product or service unless otherwise stated.

POSTMASTER: Send address changes to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

USPS 676 740
ISSN 0043 - 3284

Subscription Rates: $45 a year in the U.S.; $80 a year in foreign countries; $4 per single copy. Address communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication and mailing costs, the *West Virginia Medical Journal* will not honor claims for back issues for any reason, unless these claims are received within a 6-month period after issue of the publication requested.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

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West Virginia Medical
JOURNAL

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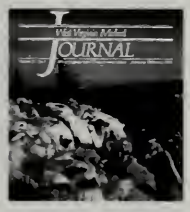

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A winter sunrise at Dolly Sods in Tucker County. Photo courtesy of *Stephen J. Shaluta Jr.,* West Virginia Department of Commerce.

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An overview of the Medicaid program in West Virginia

Editor's Note: The following article provides a historical perspective of the Medicaid program in West Virginia. It details the growth of the program and the decrease in reimbursements to providers. Much of the information is credited to the Department of Health and Human Resources Office of Medical Services (Medicaid). The WVSMA staff has compiled this information in order to educate members about the program and make them aware of the recent actions taken by the the Medicaid Crisis Panel.

What is Medicaid?

Medicaid originated 30 years ago as a federally-sponsored health insurance program for low-income people. It is the largest program providing medical and health-related services to America's poor.

Medicaid health care coverage is divided into three types which are categorized as follows:

1. Health insurance for low-income families and people with disabilities.
2. Long-term care for older Americans and those with disabilities.
3. Medigap coverage for low-income elderly that covers what Medicare will not. Each state establishes its own eligibility standards; determines the type, amount and duration of services provided; sets payment rates and administers its own program.

Forty-nine states have a Medicaid program. West Virginia began its program in 1966, one year after Congress created the program. Last year, according to the Department of Health and Human Resources (DHHR), 316,000 West Virginians received Medicaid.

The program is jointly funded by federal and state dollars. Federal funds are made available contingent on a state match that varies among states from year to year. West Virginia's match rate is the second highest in the nation with approximately 74% in federal funds and 26% in state funds. The match rate is determined by a formula that takes into account the state's per capita income compared to the national average so each state pays a larger share as their economy grows. After rising steadily between 1980 and 1992, West Virginia's match rate began to decline in 1993. As a result of these decreases, an increase in state funding was required which totaled $11 million in state FY 1995 and will require $16 million in FY 1996.

Who receives Medicaid?

With the decreases in the match rate, came increases in eligibility requirements. Federal statutes and regulations dictate who is eligible for Medicaid coverage. Over the years, Medicaid eligibility standards have been broadened to cover medical costs of the aged, blind, disabled and members of low-income families with children.

The basis for Medicaid coverage is classified as either Categorical Need or Medical Need and these groups are described as follows:

Categorically Needy include:

- Aid to Families with Dependent Children (AFDC) recipients and children
- Low-income pregnant women and children
- Supplemental Security Income (SSI) recipients or certain individuals eligible for SSI
- Low-income Medicare beneficiaries

Medically Needy include:

- Children who would be eligible for AFDC except for their income or asset levels
- Newborns whose mothers are medically needy
- Aged, blind, or disabled who would be eligible for SSI except for their income or asset levels
- Relatives taking care of children who are medically needy.

(Within both the Categorically Needy and Medically Needy categories, some coverage groups are mandatory and others are optional.)

More than 261,000 West Virginians received Medicaid benefits in January 1995. Of these recipients, 94% were classified as Categorically Needy, with the remaining 6% classified as Medically Needy. West Virginia has provided optional Medicaid coverage to the Medically Needy group since 1976.

To save money, many groups have suggested deleting the optional services, which include but are not limited to:

- Respiratory care services
- Prescription drugs
- Audiology
- Physical therapy
- Speech therapy
- Chiropractic services
- Emergency transportation

However, because of federal mandates and/or state court cases, these optional services are optional only to individuals over 21. Adult dental care was an optional service, but Medicaid stopped providing that service after the gross receipt tax passed in 1993.

For federal FY 1994, there were 47,800 recipients (13% of total recipients) who were covered under federally-mandated expansions which began in 1988. Of this total, over 27,400 were either caretaker relatives of covered recipients or pregnant women. The cost to provide care to this group for FFY 94 was $203.7 million, or 16% of the total $1.3 billion budget.

Other programs covered by Medicaid

Optional services were not the only area of expansion in the Medicaid program. In the mid 1980s, Medicaid was expanded to help defray the cost of some state-funded services, such as personal care services, long-term care hospitals, and intermediate care facilities for the mentally retarded (ICF/MR). By placing these services into the Medicaid program, West Virginia could increase its match rate by the federal government. In FY 1994, nearly $190 million of Medicaid expenditures were previously funded with state general revenue funds.

Provider enhancement tax

In theory, the idea was good, but when the federal government starting cutting back on the match rate, the dollars that were supporting social service programs were needed to pay for standard Medicaid expenses. This, along with continued federal mandated expansions, court mandates, and a lack of good management, all added to the 1991 passage of the provider enhancement tax.

This legislation established enhancement boards that were to assist the Medicaid program in developing fee schedules more comparable to national levels. Until that time, physicians were being paid 26% of the prevailing fee for their services. The provider enhancement tax legislation allowed Medicaid to increase fees and then collect as a tax, the equivalent of the state matching rate for federal dollars. These monies were then used to increase the federal matching dollars coming to the state. The program was voluntary and only impacted those physicians and others who treated Medicaid recipients.

The Physicians' Medicaid Enhancement Board set the fee schedule at .90% of the national usual and customary fee, with 23.71% of these dollars being paid back to the state in the form of a tax which was used as additional state matching dollars for federal funds. Thus, most physicians were then receiving approximately 66% of their usual and customary fees.

Tax on gross receipts

By July 1993, federal law eliminated the ability of states to use enhancement taxes to bring down federal matching funds. States that had used this system now had to develop programs that adhered to the new federal rules or go back to only state dollars being used for the federal match.

West Virginia chose to rewrite its legislation and imposed taxes on the gross revenue of ALL physicians and other providers whether they treated Medicaid beneficiaries or not. Before the new law took effect, however, Medicaid reduced rates to physicians by 30% which represented the 23.71% tax as well as an additional 6% rate reduction.

The reasoning behind the voluntary tax, the decrease in reimbursement and the new provider tax was that Medicaid continued to fall behind in their payments to providers and without extra state dollars being allocated from the general revenue fund and with the decrease in federal matching dollars, the program could not cover expenses.

Medicaid Crisis Panel

In July, Governor Caperton appointed a Medicaid Crisis Panel, which was made up of 13 voting members representing business, health care and labor, as well as, eight, non-voting legislative representatives. The voting panel members included Dr. F. Thomas Sporck, chairman of WVSMA's Legislative Committee. In addition, Dr. Thomas Scott, who is a WVSMA member and a member of the West Virginia House of Delegates, was one of the eight non-voting legislative members.

The Medicaid Crisis Panel was asked to make recommendations to bring the Medicaid budget into balance in anticipation of further reductions by the federal government, and because the DHHR had reported that the Medicaid program will have a $161 million shortfall for FY 1996. (This figure was later changed to $143 million.)

The panel made 25 recommendations which totaled $156,819,000, and many have already been implemented (Table 1). In addition, the panel made the following 22 other money-saving recommendations that do not have a dollar amount afixed to them:

Recommendation 1: The panel recommends that monies be appropriated, set aside or reserved for the acquisition of an appropriate management information system to provide the Executive and Legislative branches of government with accurate, timely and accessible financial and program information concerning all aspects of the Medicaid program.

Recommendation 2: The panel supports the implementation of a managed care program and its statewide expansion at the earliest reasonable opportunity, as a means of controlling costs in the Medicaid program. Managed care and other utilization review systems and measures are important to reducing inappropriate utilization of the system by both providers and recipients, and the panel believes that creating proper utilization incentives may be one of the most effective means of controlling costs within Medicaid.

Recommendation 3: Assuming that such reform is possible under MediGrants, the panel recommends that the Legislature, the DHHR and the public determine what constitutes essential medical services, and that we narrow our plan of benefits and eligibility under the Medicaid program based upon this examination.

Recommendation 4: The panel recommends that West Virginia's future Medicaid system under "MediGrant" structure include a comprehensive system of co-payments, in the approximate range of two percent (2%) to five percent (5%), wherever feasible and sensible from a policy perspective.

Recommendation 5: The panel recommends that for behavioral health services, restrictions be imposed so that no provider may simultaneously provide case management services and direct behavioral health services to recipients.

Recommendation 6: The panel recommends the formation of a committee to address program design and implementation issues upon adoption of the "MediGrant" program structure at the federal level.

Recommendation 7: The panel recommends the creation of a committee consisting of physicians and other qualified professionals to review situations and decisions involving expensive or long-term treatments, in an effort to identify and implement less-expensive alternatives; and to review the medical efficacy of extraordinary procedures.

Recommendation 8: The panel recommends that more coordinated and comprehensive statewide health care planning be pursued, to ensure access to services and eliminate duplicative costs in the system.

Recommendation 9: The panel recommends the indefinite postponement of any expansion of eligibility for all Medicaid programs.

Recommendation 10: The panel recommends that the Legislature consider ways in which to provide incentives to citizens to purchase long-term care insurance.

Recommendation 11: The panel recommends that appropriate changes be made to the West Virginia Code, so that the DHHR is given appropriate programmatic and budgetary control of the Medicaid program in the future. The importance of fiscal control to the long-term stability and viability of the Medicaid program cannot be overemphasized.

Recommendation 12: The panel recommends that an appropriate examination of the demographics of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) be undertaken, to make sure that there is appropriate geographic need for each FQHC and RHC which justifies the subsidy each such facility receives.

Recommendation 13: The panel recommends that the statutory penalties for providers who are found to be out of compliance with program requirements be stiffened.

Recommendation 14: The panel recommends that the DHHR cap the number of reimbursable visits to physicians' offices, without prior authorization, on a monthly or quarterly basis.

Recommendation 15: The panel recommends that the DHHR audit physician reimbursement requests for inappropriate coding, in a manner calculated to flag providers who habitually bill top codes.

Recommendation 16: The panel recommends that the Legislature and the DHHR examine the way in which out-of-state providers are reimbursed, and examine what measures can be taken to "level the playing field" between in-state and out-of-state providers.

Recommendation 17: The panel recommends that the DHHR undertake a thorough review of existing program regulations, to determine which regulations may be inappropriate, excessive or unjustified from a cost standpoint, when measured against their medical benefit.

Recommendation 18: The panel recommends that the Legislature and the DHHR review the Provider Assured Access Program (PAAS) system to look for ways to incite increased participation.

Recommendation 19: The panel recommends that the DHHR prepare a form whereby recipients of pharmaceuticals who claim that they are without resources sufficient to make the required co-payment affirm in writing, on penalty of perjury, that they have no money.

Recommendation 20: The panel recommends that the DHHR review the "transitional Medicaid" program, with a view to limiting services made available to recipients during the second six (6) months of this program to acute care services.

Recommendation 21: The panel recommends that the DHHR implement a procedure whereby physicians and other providers are denied reimbursement just as hospitals are, when payment is denied retrospectively for inappropriate utilization.

Recommendation 22: The panel recommends that the Legislature examine and consider current medical malpractice liability standards, with a view towards effecting appropriate tort reform measures so as to decrease the incidence of the practice of "defensive medicine."

Dr. Sporck's Thoughts on the Medicaid Crisis Panel

I have served at various times on other multidisciplinary panels, but never with a group quite as capable or well-intentioned as this one. Mr. Tom Heywood, who chaired the panel, is a man of incredible intellect who shepherded this group through long deliberations and helped us organize and digest an incredible amount of information.

I firmly believe that each and every member of the Medicaid Crisis Panel at the outset thought that we could make some fundamental changes in the program in terms of eligibility and services provided. We wanted to make this not only a leaner program, but a much stronger program which would really benefit those who needed it the most. However, as we deliberated it became obvious that given current federal, state, and judiciary mandates, there was very little that we could actually do with the program's structure.

When it came down to the wire, the only way in which the savings that the governor had asked for could be achieved was through further cuts in the already low reimbursement. Many of these pieces, especially the larger ones affecting hospital reimbursement and mental health reimbursement, were already in the pipeline in the DHHR. It was the consensus of the panel that no group would go without some type of cut in this effort, so physicians as well as dentists and all others who were paid on a relative value reimbursement system were cut 3%.

It is somewhat disconcerting that Medicaid was originally intended to pay for hospital and physicians' costs for poor families and children. Today, physician services account for only 10.61% of the program's expenditures, while hospital services account for about 29% of the expenditures. Thus, physician and hospital services, which were the original intent of the program, now amount to less than 40% of the entire program!

Pharmaceutical services account for about another 10% of the program's expenditures. This brings direct medical costs to about 49% of the program. The other half of the program is largely weighted toward social services and has little to do with medical care. This is a direct result of the "Medicaiding" of social services in the late 1980s and early 1990s in order to capture federal matching funds.

It is interesting to note that while children make up 52% of the beneficiaries, they account for only 16.6% of the expenditures. The category of blind, elderly, and disabled constitute only 27% of the recipients, yet account for 70% of the expenditures.

It is also important to note that physicians pay approximately 19% of the provider tax and hospitals pay approximately 44% of this tax. Of the provider tax in aggregate, about 63% is paid for by these two categories.

I encourage you to turn the page and study Table 1 which lists the recommendations made by the Medicaid Crisis Panel and the estimated savings they will achieve. While these cuts will get the program through the current year, the other 22 recommendations, in my mind, are much more important and carry the potential for real long-term restructuring and improvement of the program. Many of these recommendations assume that the federal program will change toward the Medigrant system, and that this will happen without any federal mandates. They also assume that this will no longer be an entitlement program.

Although the consensus of the panel was to support implementation of the managed care program, I made very clear my personal reservations that with our state's demographics of patients and physicians, it is unlikely that managed care will be the salvation of Medicaid in West Virginia.

I would be happy to talk to anyone at any time about the efforts of the panel. There is no doubt in my mind that this program can be improved significantly at lower costs without hurting those who truly need the coverage.

F. Thomas Sporck, M.D., F.A.C.S.

TABLE 1. MEDICAID CRISIS PANEL'S EXPENDITURE

No.	Recommendation	
1	Inpatient Hospital: Move to prospective rate setting methodology (DRG)	
2	Inpatient Hospital: Require prior authorization of hospital admissions	
3	Reduce payment for lab work and X-rays by 10%	
4	Reduce payment for durable medical equipment by 10%	
5	Reduce payment for ambulatory surgery centers by 10%	
6	Pharmacy: Establish a formulary system	
7	Pharmacy: Increase co-payments charged to recipients	
8	Pharmacy: Limit number of prescriptions received by recipient to 10 per month	
9	Pharmacy: Change reimbursement level to (AWP - 12%) + dispensing fee of $3.90	
10	Pharmacy: Other miscellaneous	
11	Nursing Homes: Remove occupancy incentive; case mix adjustment to the minimum level	
12	Inpatient Psychiatric: [a] Reduce payments for under 21	
	Inpatient Psychiatric: [b] Additional reductions through utilization review	
13	Behavioral Health: Reduction of case management services	
14	Behavioral Health Code changes	
15	Pharmacy/Nursing Homes: Recycling of unused drugs	
16	Additional Behavioral Health Reductions	
	Consisting of:	
	Outpatient Behavioral Health: Narrowing the diagnosis and functional levels of clients being served	
	• for Rehabilitation Services	$ 8,500,000
	• for Clinic Services	3,400,000
	• Review of bundled rates for the child care	1,000,000
	• Development of bundled rates for adult residential	1,500,000
	• Basic Living Skills	1,900,000
	• ICF/MR -- Medpass Program for ICR/MR	1,000,000
	• MR/DD WAIVER -- Control growth in program, reserving 90 slots for the clients coming out of Colin Anderson Center	2,700,000
	SUBTOTAL	$20,000,000
17	Reduce reimbursement rate for personal care from $7.47 per unit to $5 per unit	
18	Physician Rate Reduction 3% (Rate Reduction ◄► Co-Pays)	
19	Implementation of RBRVS reimbursement methodology	
20	Reduce Home Health reimbursement rate to 90% average Medicare	
21	Cap Aged/Disabled Wavier Program	
22	Eliminate General Assistance for Disabled Adults Program	
23	3% RBRVS -- Extension of conversion factor to other providers on RBRVS system	
24	ICF/MR -- Additional reductions	
25	Extension of 3% equivalent reduction to providers not otherwise reduced	
	TOTAL	

REDUCTION RECOMMENDATIONS

Estimated Savings	Running Totals	Implementation Schedule
$40,000,000	$40,000,000	Implemented
7,500,000	47,500,000	Implemented
752,000	48,252,000	2/1/96
1,372,000	49,624,000	2/1/96
80,000	49,704,000	2/1/96
14,000,000	63,704,000	9/1/96
2,000,000	65,704,000	Implemented
750,000	66,454,000	Implemented
6,504,000	72,958,000	Implemented
2,800,000	75,758,000	Implemented
4,750,000	80,508,000	3/1/96 & 4/1/96
8,400,000	88,908,000	Implemented
1,600,000	90,508,000	3/1/96 & 4/1/96
10,000,000	100,508,000	Implemented
3,795,000	104,303,000	Implemented
2,000,000	106,303,000	2/1/96
20,000,000	126,303,000	
		2/1/96
		2/1/96
		Implemented
		3/1/96 & 4/1/96
		Implemented
		Requires legislative change, could be implemented 7/1/96
		Implemented
8,700,000	135,003,000	2/1/96
4,050,000	139,053,000	3/1/96 & 4/1/96
4,750,000	143,803,000	Implemented
1,500,000	145,303,000	2/1/96
3,792,000	149,095,000	Implemented
2,100,000	151,195,000	Under review by Asst. Attorney General for DHHR, requires court action
432,000	151,627,000	3/1/96 & 4/1/96
4,000,000	155,627,000	Requires consulting assistance, could be implemented 9/1/96
1,192,000	156,819,000	3/1/96 & 4/1/96
	$156,819,000	

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NOTE: The usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever, is penicillin given by the intramuscular route. Cefprozil is generally effective in the eradication of *Streptococcus pyogenes* from the nasopharynx; however, substantial data establishing the efficacy of cefprozil in the subsequent prevention of rheumatic fever are not available at present.
Otitis Media caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Moraxella (Branhamella) catarrhalis.* (See CLINICAL STUDIES section.)
NOTE: In the treatment of otitis media due to beta-lactamase producing organisms, cefprozil had bacteriologic eradication rates somewhat lower than those observed with a product containing a specific beta-lactamase inhibitor. In considering the use of cefprozil, lower overall eradication rates should be balanced against the susceptibility patterns of the common microbes in a given geographic area and the increased potential for toxicity with products containing beta-lactamase inhibitors.

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Pseudomembranous colitis has been reported with nearly all antibacterial agents, and may range from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.
Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis."
After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibacterial drug effective against *Clostridium difficile.*

PRECAUTIONS
General
Evaluation of renal status before and during therapy is recommended, especially in seriously ill patients. In patients with known or suspected renal impairment (see DOSAGE AND ADMINISTRATION), careful clinical observation and appropriate laboratory studies should be done prior to and during therapy. The total daily dose of CEFZIL® (cefprozil) should be reduced in these patients because high and/or prolonged plasma antibiotic concentrations can occur in such individuals from usual doses. Cephalosporins, including CEFZIL, should be given with caution to patients receiving concurrent treatment with potent diuretics since these agents are suspected of adversely affecting renal function.
Prolonged use of CEFZIL may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Cefprozil should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Positive direct Coombs' tests have been reported during treatment with cephalosporin antibiotics.

Information for Patients
Phenylketonurics: CEFZIL for oral suspension contains phenylalanine 28 mg per 5 mL (1 teaspoonful) constituted suspension for both the 125 mg/5 mL and 250 mg/5 mL dosage forms.

Drug Interactions
Nephrotoxicity has been reported following concomitant administration of aminoglycoside antibiotics and cephalosporin antibiotics. Concomitant administration of probenecid doubled the AUC for cefprozil.

Drug/Laboratory Test Interactions
Cephalosporin antibiotics may produce a false-positive reaction for glucose in the urine with copper reduction tests (Benedict's or Fehling's solution or with Clinitest®[1] tablets), but not with enzyme-based tests for glycosuria (e.g., Tes-Tape®[2]). A false-negative reaction may occur in the ferricyanide test for blood glucose. The presence of cefprozil in the blood does not interfere with the assay of plasma or urine creatinine by the alkaline picrate method.

Carcinogenesis, Mutagenesis, and Impairment of Fertility
No mutagenic potential of cefprozil was found in appropriate prokaryotic or eukaryotic cells *in vitro* or *in vivo*. No *in vivo* long-term studies have been performed to evaluate carcinogenic potential.
Reproductive studies revealed no impairment of fertility in animals.

Pregnancy: Teratogenic Effects. Pregnancy Category B
Reproduction studies have been performed in mice, rats, and rabbits at doses 14, 7, and 0.7 times the maximum daily human dose (1000 mg) based upon mg/m^2, and have revealed no evidence of harm to the fetus due to cefprozil. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Labor and Delivery
Cefprozil has not been studied for use during labor and delivery. Treatment should only be given if clearly needed.

Nursing Mothers
It is not known whether cefprozil is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when CEFZIL is administered to a nursing mother.

Pediatric Use
Safety and effectiveness in pediatric patients below the age of 6 months have not been established. However, accumulation of other cephalosporin antibiotics in newborn infants (resulting from prolonged drug half-life in this age group) has been reported.

Geriatric Use
Healthy geriatric volunteers (≥ 65 years old) who received a single 1 g dose of cefprozil had 35%-60% higher AUC and 40% lower renal clearance values when compared to healthy adult volunteers 20-40 years of age. In clinical studies, when geriatric patients received the usual recommended adult doses, clinical efficacy and safety were acceptable and comparable to results in non-geriatric adult patients.

ADVERSE REACTIONS
The adverse reactions to cefprozil are similar to those observed with other orally administered cephalosporins. Cefprozil was usually well tolerated in controlled clinical trials. Approximately 2% of patients discontinued cefprozil therapy due to adverse events.
The most common adverse effects observed in patients treated with cefprozil are:
Gastrointestinal — Diarrhea (2.9%), nausea (3.5%), vomiting (1%), and abdominal pain (1%).
Hepatobiliary — Elevations of AST (SGOT) (2%), ALT (SGPT) (2%), alkaline phosphatase (0.2%), and bilirubin values (< 0.1 %). As with some penicillins and some other cephalosporin antibiotics, cholestatic jaundice has been reported rarely.
Hypersensitivity — Rash (0.9%), urticaria (0.1%). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy.
CNS — Dizziness (1%). Hyperactivity, headache, nervousness, insomnia, confusion, and somnolence have been reported rarely (< 1%). All were reversible.
Hematopoietic — Decreased leukocyte count (0.2%), eosinophilia (2.3%).
Renal — Elevated BUN (0.1%), serum creatinine (0.1%).
Other — Diaper rash and superinfection (1.5%), genital pruritus and vaginitis (1.6%).
The following adverse events, regardless of established causal relationship to CEFZIL, have been rarely reported during post-marketing surveillance: anaphylaxis, colitis (including pseudomembranous colitis), erythema multiforme, fever, serum-sickness like reactions, Stevens-Johnson Syndrome and thrombocytopenia.

Cephalosporin-class paragraph
In addition to the adverse reactions listed above which have been observed in patients treated with cefprozil, the following adverse reactions and altered laboratory tests have been reported for cephalosporin-class antibiotics:
Aplastic anemia, hemolytic anemia, hemorrhage, renal dysfunction, toxic epidermal necrolysis, toxic nephropathy, prolonged prothrombin time, positive Coombs' test, elevated LDH, pancytopenia, neutropenia, agranulocytosis.
Several cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment, when the dosage was not reduced. (See DOSAGE AND ADMINISTRATION and OVERDOSAGE.) If seizures associated with drug therapy occur, the drug should be discontinued. Anticonvulsant therapy can be given if clinically indicated.

OVERDOSAGE
Cefprozil is eliminated primarily by the kidneys. In case of severe overdosage, especially in patients with compromised renal function, hemodialysis will aid in the removal of cefprozil from the body.

CLINICAL STUDIES
Study One:
In a controlled clinical study of **acute otitis media** performed in the United States where significant rates of beta-lactamase producing organisms were found, cefprozil was compared to an oral antimicrobial agent that contained a specific beta-lactamase inhibitor. In this study, using very strict evaluability criteria and microbiologic and clinical response criteria at the 10-16 days post-therapy follow-up, the following presumptive bacterial eradication/clinical cure outcomes (*i.e.*, clinical success) and safety results were obtained:

U.S. Acute Otitis Media Study
Cefprozil vs. beta-lactamase inhibitor-containing control drug

Efficacy: Pathogen	% of Cases with Pathogen	Outcome
	(n = 155)	
S. pneumoniae	48.4%	cefprozil success rate 5% better than control
H. influenzae	35.5%	cefprozil success rate 17% less than control
M. catarrhalis	13.5%	cefprozil success rate 12% less than control
S. pyogenes	2.6%	cefprozil equivalent to control
Overall	100.0%	cefprozil success rate 5% less than control

Safety:
The incidence of adverse events, primarily diarrhea and rash,* were clinically and statistically significantly higher in the control arm versus the cefprozil arm.

Age Group	Cefprozil	Control
6 months – 2 years	21%	41%
3 – 12 years	10%	19%

* The majority of these involved the diaper area in young children.

Study Two:
In a controlled clinical study of **acute otitis media** performed in Europe, cefprozil was compared to an oral antimicrobial agent that contained a specific beta-lactamase inhibitor. As expected in a European population, this study had a lower incidence of beta-lactamase-producing organisms than usually seen in U.S. trials. In this study, using very strict evaluability criteria and microbiologic and clinical response criteria at the 10-16 days post-therapy follow-up, the following presumptive bacterial eradication/clinical cure outcomes (i.e., clinical success) were obtained:

European Acute Otitis Media Study
Cefprozil vs. beta-lactamase inhibitor-containing control drug

Efficacy: Pathogen	% of Cases with Pathogen	Outcome
	(n = 47)	
S. pneumoniae	51.0%	cefprozil equivalent to control
H. influenzae	29.8%	cefprozil equivalent to control
M. catarrhalis	6.4%	cefprozil equivalent to control
S. pyogenes	12.8%	cefprozil equivalent to control
Overall	100.0%	cefprozil equivalent to control

Safety:
The incidence of adverse events in the cefprozil arm was comparable to the incidence of adverse events in the control arm (agent that contained a specific beta-lactamase inhibitor).

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2. Tes-Tape® is a registered trademark of Eli Lilly and Company.

Revised June 1995
7718DIM-06

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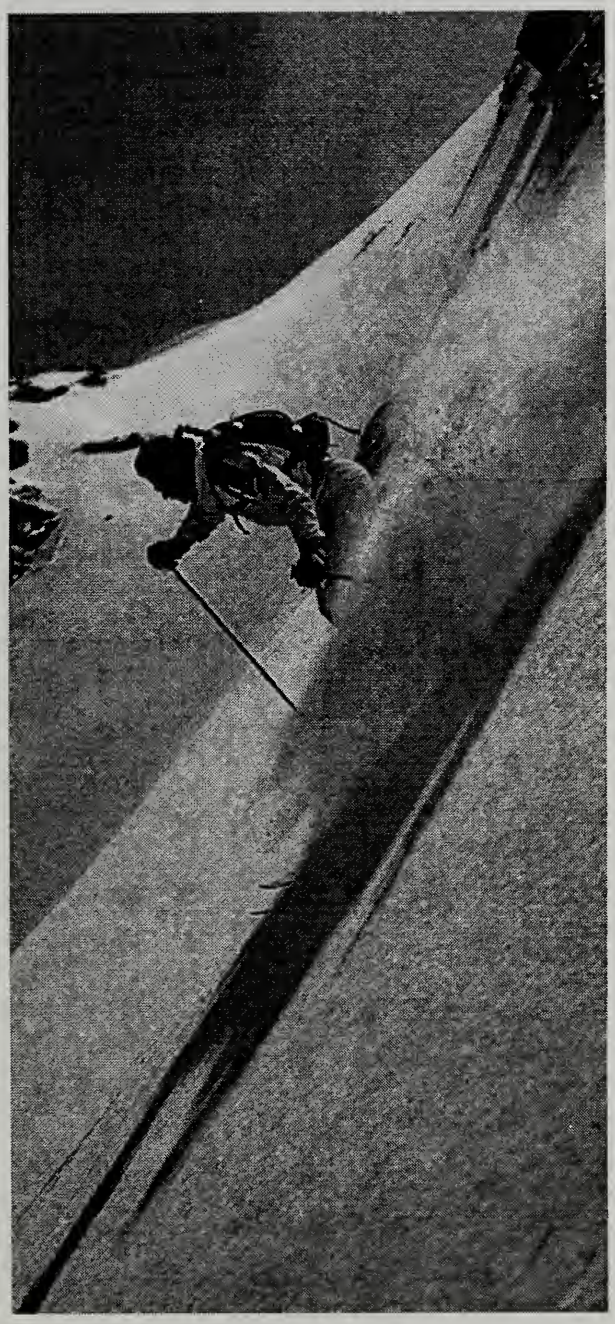

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Mental health reform: A practical approach

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Abstract

This paper outlines a practical and pragmatic approach to containing mental health costs, especially when caring for Medicaid recipients. The role of psychiatrists as primary care gatekeepers in the managed care system is also discussed. We conclude that a single-payor system seems to be the best alternative for timely and quality mental health care, and that early detection via education and screening for families predisposed to substance abuse/mental illness is also beneficial in controlling costs.

Introduction

Unlike federal health care reform which is driven by middle class concerns about access, quality and cost, state reforms are necessary to contain costs in behavioral health (1).

The false notion that mental health care has no endpoints or positive outcomes has resulted in discrimination by corporate executives, insurance companies, and managed care. This notion has fueled the mental health cost fire, forcing a vulnerable section of society to utilize the public sector.

Medicare discriminates against the mentally ill in regard to reimbursement issues, though attempts are being made to achieve parity with other medical illnesses. Children and adolescents are contributing to escalating mental health costs, forcing Louisiana and California to opt for managed care. Failure to limit the types of providers in the Medicaid system has escalated the problem. For example, over the past five to 10 years in West Virginia the number of behavioral health providers has increased from 14 to 125 and has created a fiscal nightmare. The majority of these individuals are not physicians because managed care companies use other types of health care providers for counseling and psychotherapy, with general practitioners and internists acting as medication managers in order to cut costs. Treatment is thus fragmented and quality decreased.

Behavioral management companies have further escalated this problem by whetting their drive for profits at the expense of the physician and patient -- they profit by denying care. As Professor Uwe Reinhardt, Ph.D., said in a report in the *New England Journal of Medicine*, "The private HMO managers have become literal bounty hunters who are unleashed on the system and are allowed to carve out for themselves, mainly from the hides of the doctors, enormous profit margins, and government and payers take no notice. That's why outfits such as U.S. Health Care are able to keep 30 cents of every premium dollar for administration, marketing and profit."

Ethical issues are forgotten and treatment is delayed while caregivers negotiate for permission to provide care. Few managed care firms divulge review criteria, forcing providers to guess at how to get reimbursed. Managed care firms will only retain a provider whom they define as cost effective, cooperative, and having a high level of patient satisfaction. Denials of necessary admissions cause frequent requests for appeals. These are often denied, are time consuming and are not reimbursable and are frustrating and humiliating for physicians. In addition, since courts have absolved managed care companies of legal responsibilities for patients who have adverse consequences due to a denied admission, psychiatrists frequently have to deal with a disproportionate percentage of the sickest, most suicidal and litigious patients. Legislators, usually lawyers or laymen, do not understand the needs of such vulnerable patients.

Studies have shown that non-discriminatory mental illness and substance abuse benefits are not only affordable ($250/year) (2), but decrease costs both directly and indirectly by using the most up-to-date managed care strategies. It is important to note the following statistics:

* 28% of the population at any one time will have a mental or substance abuse disorder.
* 60% of all mentally-ill patients receive some form of government help (state, federal, or local) as opposed to 40% of general medical care patients. In rural areas such as West Virginia, this figure is much higher (70%-75%).
* 50% of patients with mental illness do not utilize psychiatric treatment today.
* Managed care private sector data does not reflect actual psychiatric needs because it is often underreported, denied or minimized.
* Currently, there are 12 psychiatrists/100,000 population. HMO projects a need of 4-5/100,000, which is based on fiscal not factual needs.
* Psychiatric care in the U.S. is the best in the world, in quality, quantity and timeliness.

Role of the psychiatrist

Psychiatrists, by virtue of their extensive biopsychosocial training, are critical "team members" and empowered leaders who are uniquely qualified to manage, lead and integrate the multidisciplinary treatment of patients with serious psychiatric illness (4).

A psychiatrist treatment team leader who can utilize multiple therapeutic modalities simultaneously often leads to a better outcome and lowers costs. Managed care has

heightened the importance of this role by requiring that patients be treated in less-restrictive settings in the most cost efficient way.

Psychiatrists should resist the role of medication manager and should never prescribe medications for referred patients without agreeing on the diagnosis and a multidisciplinary treatment plan, which requires input from the patient and team members. The decision to provide or deny medication should not be left to health care providers who are not psychiatrists.

The problem with managed care is that control is largely in the hands of non-medically trained or experienced individuals whose cardinal principle guiding decisions seems to be to contain costs by limiting access. No field of medicine has been distorted and compromised by managed care as much as psychiatry, and no patients have been shortchanged and abused by managed care as much as those suffering from significant psychiatric disorders.

Managed care has taken the diagnosis and treatment of psychiatric disorders out of the hands of psychiatrists and assigned them to individuals who may know little about the diagnosis, differential diagnosis, neurobiology, pharmacology, genetics, epidemiology and treatment of serious mental illnesses. Alternative providers may include social workers, counselors or nurses who do not have the formal education or clinical experience in mental hospitals to care for patients whose psychiatric disorders are complicated by serious medical illness.

The ratio of psychiatrists to potential patients in such managed care systems is one psychiatrist for 60,000 to 100,000 "lives." Statistics show that among any 60,000 to 100,000 "lives" enrolled in a typical managed care plan, approximately 15,000-20,000 will have disabling psychiatric conditions. It is obvious that most managed care systems do not take psychiatric illnesses seriously and reject the biopsychosocial medical model of psychiatry. Few individuals under managed care see a psychiatrist for diagnosis, treatment, or evaluation and monitoring of their response to therapy.

Issues for clinical psychiatrists

The American Academy of Clinical Psychiatry published the following outline in their *Consensus Statement on the Treatment of Mental Disorders* (4):

I. Universal Access to Basic Healthcare

The role of psychiatrists is clearcut and unequivocal -- they are the professionals best qualified to conduct comprehensive evaluation and treatment of patients with problems related to mental disorders. Making psychiatry a primary care specialty and psychiatrists gatekeepers for mental health, just as internists and family practitioners are for general medical health, is fiscally sound advice and would result in the highest quality of care for the dollar invested.

II. Managed Care (5,6)

In order to preclude costly and intrusive obstacles to quality patient care, we must develop a scenario where payers allow providers to assume the responsibility for quality monitoring and utilization review of the services rendered and which includes parity of treatment of mental illness/substance abuse with other medical illnesses. In essence, psychiatrists would assume responsibility for managing the care rendered within the system. Physicians and their patients have the right to contract privately outside any health plan, provided they follow the general economic and clinical guidelines set forth by national organizations (e.g. AMA, APA, etc.). Utilization review criteria and managed care laws need to be developed to protect the patient and physician from economic and quality medical care abuse by such companies. The best solution, for the needs and concerns of psychiatrically-ill individuals to be properly met, would be specific, negotiated per-enrollee fees for psychiatric care (though different for acute and chronic mentally ill). The fund would cover all care, inpatient and outpatient, provided by psychiatrists, psychologists, social workers, and other mental health professionals, all working under the direction and responsibility of psychiatrists. Such arrangements would require systematic monitoring of the quality of care provided. Mental health professionals who are not medically trained have an important and necessary place in the care of many psychiatric conditions, but their optimal help requires psychiatric involvement, judgement and ultimate overall responsibility for the care and treatment of the patient.

III. Miscellaneous

We are opposed to a number of practices that have denied care to the mentally ill in recent years:

1. The use of preexisting conditions to deny care under insurance programs.
2. The use of preferential, rather than community, rates in order to make insurance more expensive to those who need it, and less expensive to those who may not use it.
3. The creation of insurance programs for those who are likely to be healthy (the young, the working, the educated, the successful), and deny them to those who are likely to be sick (children, the poor, the elderly).
4. The use of financial arrangements to make it impossible for the less fortunate to obtain medical coverage. This is the case when most of the resources are concentrated in programs that deny services to those who are most likely to use such services (e.g. chronic schizophrenics).

Recommendations

To achieve the American Academy of Clinical Psychiatry's goals we recommend the following:

1. **Limiting:**

a) The number of office visits to 30/year, medication evaluation or psychotherapy, depending on the patient's needs;

b) Hospital stays to 25-30 days/year or day hospital visits to 50-60/year (substance abuse and mental illness inclusive);

c) Intensive residential care to 60-75 days (for selected adolescents -- criteria to be developed -- perdiem or bundled rate). Most adolescents can be treated either in outpatient or partial treatment programs.

2. Outpatient authorization should be generous initially (10-15 sessions) with request for more sessions on a needed basis. For medication maintenance, 8-12 sessions per year are adequate.
3. Psychotherapy -- 20% copayment for first 10 sessions (for private and insured patients), and 50% copayment for remaining sessions (up to a maximum of 30/year).
4. For Medicaid patients, a copayment of $2/visit for medication management and $5/visit for psychotherapy; (sessions to be equally divided, but interchangeable between psychotherapy and medication management). This will need a federal waiver.
5. A patient protection act, giving the patient the right to choose any willing, qualified provider needs to be developed. Due process should be given for termination if they do not follow such guidelines.
6. Licensure for behavioral health centers which have mushroomed in West Virginia to over 125, should be more stringent. Private sector providers of such centers should follow the same guidelines as community mental health centers (this does not apply to office practices) with periodic inspection of such centers. Partial (day) hospitals should either be affiliated with hospitals or community mental health centers. Their number needs restriction and should depend on the needs of the population they serve by requiring a CON.
7. Computerized health credit cards for health purposes need to be developed. These cards should contain health information and depict the number of visits allowed and used, including deductibles, for inpatient, day program and outpatient appointments. Decreased cost, increased compliance, decreased stigma of the welfare card, decreased adversarial relationship between provider/patients (due to decreased need for collection agencies), and decreased abuse of medicine and doctor shopping would be added benefits. For Medicaid patients, the $2-$5 deductible could be paid either by cash or via the card, which would deduct this said amount from the patient's welfare check. This money would be reimbursed to the user once he/she submits the receipts to the state either semi-annually or annually (or through income tax refund). This will also increase the state's reimbursement from the federal government ($3 for every $1 collected). Similar concepts need to apply to private, Medicare, and insured patients. Rates, dependent upon usage, need to be adjusted annually with their health insurance premium, especially if a health savings account is being used which will not only be cost effective but will provide choice to all parties concerned. This is of paramount importance (but not to the insurance companies) and was the main reason for the defeat of the Clinton Plan.
8. Perdiem or bundled inpatient and day hospital rates must be developed at national and state levels for each diagnosis, and like DRGs, include length of stay. This will force hospitals to offer cost effective care to increase their profitability and decrease unnecessary procedures such as lab and X-ray, CT scan, MRI, etc.
9. Itemized billing for services should be provided to patients and the insurance company (to justify even perdiem/bundled charges).
10. Consultants for managed care should not be full-time employees of insurance companies or managed care firms since they are often zealous in denials and cost cutting, forgetting need and quality of care. They should preferably be from the same geographical area or state.
11. Recruitment of local professionals is essential since they have knowledge of the local human service system, have personal stakes and reputation involved, as well as a relationship with local mental health/ substance abuse programs and systems.
12. Fee guidelines, highest for outpatient, least for inpatient, and intermediate for day programs, must be developed. Rates should be adequate with incentives for such patients to be treated in the least restrictive environment.
13. Drug prices should be affordable. For example, even though SSRIs in the long run are more cost effective than tricyclic antidepressants (taking into account side effects and drug overdose), they are still fairly expensive and out of reach of many citizens. Private and local pharmacies should be entitled to the same discount by pharmaceutical firms as given to larger chains, HMOs, and managed care companies, to provide timely, competitive and quality care.

Mental retardation

1. Should be dealt with on the basis of individual need.
2. Reimbursement rates for care of the mentally retarded need to be reduced since management is lifelong with considerable duplication of services by agencies.
3. While initial care and evaluation can be done in a community mental health center (CMHC) setting (1-3 months for both patient/caregivers), further care should be done at home or in personal care homes. It is our opinion that one case worker from the CMHC can manage and supervise 8 - 12 such patients at a cost of $2,000-$3,000/year per patient, as opposed to the current $25,000/year per patient (excluding the cost of residential care).
4. Another cost effective and humane way of providing care is at home. In this scenario, parents or relatives are provided $6,000/year by the state to provide care at home (irrespective of their income). Quality of care and abuse can be addressed by periodic visits by case managers either from DHS or mental health centers (full-time employees of such agencies with no reimbursement for such visits).
5. Advocates and advocacy laws need to be revamped because they often act as a hindrance to quality care and are more costly.

Medicaid

1. Problems are inherent with the welfare system because it is being used as a full-fledged insurance system, and it is abused by those involved with its costs which have risen from $50 billion to $140 billion in 1994. Some statistics on Medicaid worth noting are that:
   * 50% of the children who receive Medicaid consumed 19% of the Medicaid budget.
   * Elderly, blind and disabled, although 27% of the Medicaid population, consumed 67% of the Medicaid budget.

* Other adults comprise 23% of the Medicaid population, but consumed 14% of the Medicaid budget.
* In 1991 in WV, the Medicaid budget was $507 million. The 1994-1995 Medicaid budget was $1.38 billion.
* It is difficult for legislators to tell Medicaid recipients that Medicaid can provide only minimum coverage and not full-fledged health care that everyone desires.

2. Massachusetts Mental Health Managed Care Plan (8)

   While the Massachusetts Mental Health Managed Care Plan decreased mental health cost by use of prior approval for admission, utilization review, use of alternate outpatient treatments, and selecting contractors, it is still not clear whether it decreased access to care or made an actual reduction in cost. Consumer satisfaction, access to care and quality have not been measured. Increased readmission rate for children and possibly adolescents was also noticed.

3. Managed Care (10)

   Currently 23% of the Medicaid program nationally is under managed care and this figure is expected to rise to 75% by the year 2000. Managed care will reduce excess services, but it will also decrease quality and accessibility. To avoid this scenario, a committee of qualified professionals needs to be created for all areas of mental health to develop guidelines and act as a think-tank. This will be especially critical in areas where excess utilization and abuse is rampant (e.g., case management, ambulance utilization, adolescent and children sector, etc.). Social problems such as unwed and teenage mothers, should not be included in the behavioral health budget in order to obtain more federal dollars. If society feels there is a need for such a system, it should be funded from general taxation.

Finally, to preserve choice for both patients and physicians, a single payor system with basic coverage for mental health, with state and federal government acting as intermediaries and following APA guidelines, seems to be the best alternative to the present system. Increasing revenues for mental health by increasing taxes on alcohol, cigarettes, firearms and ordinances, and investing it on preventive mental health and education (e.g., smoking cessation, early screening of depression, and alcoholism in predisposed families) will be effective in cost, quality and timeliness in the long run.

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Non-invasive mechanical ventilation: The benefits of the BiPAP system

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Abstract

Many of the complications with endotracheal intubation and invasive mechanical ventilation can be avoided with the use of non-invasive mechanical ventilation (NIMV). This technique has been especially successful in treating patients with acute respiratory failure (ARF). NIMV improves gas exchange, avoids complications caused by endotracheal intubation, and allows patients to talk and take medications orally. This article reviews our experiences treating 27 patients with ARF with a BiPAP (bi-level positive airway pressure) ventilator. This is a portable unit which allows for selection of different modes of ventilation and adjustment of inspiratory and expiratory pressures. Non-invasive mechanical ventilation should be considered in patients presenting with ARF who are hemodynamically stable and in whom spontaneous breathing is preserved.

Introduction

Mechanical ventilation is used in the treatment of acute respiratory failure (ARF) once medical therapy and oxygen administration fail to improve gas exchange. In the acute setting, mechanical ventilation is administered either through an endotracheal or a tracheostomy tube. These approaches make mechanical ventilation an invasive therapeutic modality which carries a significant morbidity and mortality (1).

During the last century and until the mid 1950s, mechanical ventilation was a non-invasive procedure. Initial negative pressure ventilators evolved into respirators of the "iron lung" type which proved to be effective in treating acute respiratory failure, and greatly reduced mortality during the poliomyelitis epidemic. Other types of negative pressure ventilators were also developed such as the cuirass, jacket-type ventilators and pneumobelt.

Despite the success of negative pressure ventilators in treating respiratory failure resulting from respiratory muscle dysfunction, this type of ventilatory approach was less effective in the treatment of respiratory failure caused by parenchymal lung disease and conditions where the patient's central respiratory drive was impaired. In addition, the large size and weight of the "iron lung" models, their lack of portability, and difficulty in caring for patients with chest tubes and intravenous lines, made negative pressure ventilators less than optimal in the care of patients with acute respiratory failure.

The development of positive pressure ventilation during the 1950s and the implementation of intensive care units caused a decline in the interest and use of any modality of non-invasive mechanical ventilation (NIMV). Fortunately, in the last three decades, significant advances in the understanding and development of positive pressure ventilators have been made. However, complications arising from their use (barotrauma, impairment of cardiovascular function), or in association with endotracheal intubation (tracheolaryngeal trauma, nosocomial infections, lack of oral communication, discomfort) have caused renewed interest in non-invasive mechanical ventilation (2). This interest has been reinforced by the introduction of a new generation of portable positive pressure ventilators and new types of nasal masks (3,4).

NIMV: The new era

Even though some improvements in negative pressure ventilators were made during the era of invasive mechanical ventilation, negative pressure ventilation was relegated almost exclusively to home or rehabilitation hospitals to treat chronic respiratory failure caused primarily by neuromuscular diseases. However, uncontrolled studies during the late 1980s indicated that NIMV could have a role in the treatment of some cases of acute respiratory failure.

In one study, Marino and colleagues (5) reported a positive outcome in a group of patients with acute respiratory failure who were treated with NIMV using a face mask. Also, Wysocky et al (6) used pressure-support ventilation delivered with a tight face mask to treat 17 patients with impending acute respiratory failure who otherwise would have required endotracheal intubation by clinical and gas exchange criteria. In nine of these patients, intubation was avoided.

In another report, Udwadia et al (7) reported the use of NIMV to aid in the weaning of 22 patients who had failed the weaning process through conventional methods. With the aid of non-invasive ventilation delivered by nasal mask, 20 of these 22 patients were successfully weaned and extubated.

The potential benefit of NIMV as a weaning aid has also been confirmed recently by Restric et al (8). These physicians successfully weaned 10 ventilatory dependent COPD patients, who had also failed the conventional weaning process by extubating them and then continuing NIMV through a nasal mask.

In two other reports (9,10), non-invasive ventilation was also used to treat 36 patients with a volume-cycled ventilator in the assist control mode delivered with a nasal mask. All of these patients would have required endotracheal intubation, but utilizing

this approach 75% of the cases successfully avoided intubation. Many of the patients who did require intubation had altered mental states, so this may have contributed to failure in some cases.

The studies which have been mentioned suggest a potential application of NIMV in treating critically-ill patients. The use of NIMV is now becoming much more acceptable since more physicians are gaining experience with this technique and more comfortable and better-fitted nasal masks are available, as well as the fact that compact portable pressure support ventilators like the BiPAP system have been introduced. In addition, NIMV is gaining popularity because it offers the potential for treating respiratory failure patients with a simplified, cost-effective approach.

The BiPAP system

The Bi-level Positive Airway Pressure (BiPAP) System (Respironics Inc., Murrysville, Pa.) is a device which functions as a time-cycled, pressure-limited ventilator. Unlike nasal CPAP, the unit can deliver different pressures during inspiration (IPAP) and expiration (EPAP). It is portable and has cost advantages over conventional positive pressure ventilators and standard portable volume ventilators. In addition, it provides different types of respiratory modes which interact with patients' demands.

Besides improving gas exchange and reducing the work of breathing, NIMV with a BiPAP unit presents the attractive concept of avoiding endotracheal intubation and its complications. In addition, ventilation with the BiPAP system offers significant benefits over invasive ventilation because patients can talk, take oral medications, and may even be fed orally. Also, the risk of nosocomial pneumonia and the need for prior humidification of the inhaled gases could theoretically be reduced.

The BiPAP system has a variety of modes: IPAP, EPAP, Spontaneous, Spontaneous/Timed (S/T), and Timed (T). Although the IPAP and EPAP can be used independently, usually both of them are used simultaneously upon selection of the *spontaneous* mode. In the spontaneous mode, the patient is in control of the respiratory rate, and when inspiration is started the machine diverts flow to satisfy the patient's inspiratory demands and preset pressure (IPAP). The delivered tidal volume in the spontaneous mode will be dependent upon the pressure differential between IPAP and EPAP levels and the combined resistance and compliance of the circuit and the patient.

In the *S/T* mode, the ventilator also delivers mechanical breaths if the patient does not initiate a spontaneous breath within the interval determined by the preset rate. The unit works in a very similar way to the combination of pressure support ventilation (PSV) and extended mandatory minute ventilation (EMMV) frequently used with conventional positive pressure ventilation. However, in this instance the system ensures a minimal respiratory rate instead of minute ventilation. With the S/T mode, the patient is in control of the respiratory rate as long as it exceeds the number of the set breaths per minute (BPM).

In the *timed* mode, in addition to the EPAP, IPAP, and rate (BPM), the desired length or percent of IPAP can also be set. This mode is very similar to the S/T with the only difference being that once it is activated, the percentage of inspiratory time is fixed.

BiPAP ventilators were initially used in the treatment of chronic respiratory failure in a domiciliary setting. During the end of the last decade, the BiPAP ventilator started to be used in the intensive care area and different reports have claimed success treating diverse types of acute respiratory failure with it.

Experiences with BiPAP

Pennock and his group (11,12), have obtained the most significant statistics on the success rate of BiPAP in treating patients with acute respiratory failure resulting from a variety of medical and surgical conditions. In their study, they selected patients presenting with respiratory distress, hypoxemia, and hypercarbia, who were considered candidates for endotracheal intubation. In 80% of 110 episodes, intubation was avoided, and the mean length of treatment with BiPAP was 2.6 (range 1-6) days.

In another report, Lapinsky et al (13) showed that patients with respiratory failure secondary to left ventricular failure may be treated successfully with BiPAP. They claim that in addition to the improvement in respiratory functions, the increase in intrathoracic pressures induced by BiPAP will decrease left ventricular transmural pressures and decrease the afterload, thus also improving cardiovascular function.

Our study

At Ruby Memorial Hospital, we reviewed the outcome of patients treated with BiPAP during a six-month period. A total of 26 patients were studied, and one patient was treated with BiPAP twice. Nineteen of the patients were males and the mean age was 57 years.

The clinical conditions patients presented with were as follows: COPD exacerbation (8), ARDS/sepsis (6), multiple trauma (3), cardiogenic pulmonary edema (5), post-polio syndrome (2), atelectasis (2), and obstructive sleep apnea (1). Days on BiPAP and maximal values for EPAP and IPAP for each patients were recorded. The values of arterial blood gases and PaO_2/FiO_2 ratio before and one hour post implementation of BiPAP were also examined.

For analysis we considered two groups: the post-extubation and the "de novo" group. The post-extubation group included patients in whom respiratory status deteriorated following extubation and who were considered for reintubation. The de novo group included patients presenting with respiratory distress and gas exchange abnormalities and in whom endotracheal intubation was contemplated.

Results

Of the 27 episodes of acute respiratory failure, 21 responded to BiPAP. Six patients, three in each group, required intubation and invasive mechanical ventilation. The response was slightly better in the de novo group and in patients with hypercarbic failure (Table 1). There was no significant difference in duration of BiPAP therapy (2 ± 1 days in the post-extubation group and 3 ± 2 days in the de novo group).

Following implementation of BiPAP, there was a significant decrease in PaCO2 (52 ± 4 vs. 44 ± 2) and increase in pH (7.38 ± 0.06 vs. 7.42 ± 0.04). Although there was an improvement in PaO2 and PaO2/FiO2 ratio, the difference did not reach significant levels (Table 2).

Guidelines for use of BiPAP

From previous publications and our own experience, patients considered for NIMV with a BiPAP system should be cardiovascularly stable. In addition, the underlying condition responsible for respiratory failure should be expected to be controlled or start to improve within the next 24-48 hours.

Table 1. Outcome of respiratory failure episodes treated with BiPAP.

	Number of cases	Responders	Non-responders
Post-Extubation	10	7	3
De Novo	17	14	3

Table 2. Values for gas exchange variables before and after BiPAP.

	Before	After	P value
$PaCO_2$ (mm Hg)	52 ± 4	44 ± 2	< 0.02
pH	7.38 ± 0.06	7.42 ± 0.04	< 0.02
PaO_2 (mm Hg)	83 ± 34	85 ± 31	NS
FiO_2	0.52 ± 0.31	0.47 ± 0.20	NS
$Pa0_2/FiO_2$	156 ± 27	180 ± 15	NS

Table 3. Indications for non-invasive mechanical ventilation for acute respiratory failure.

- COPD exacerbation
- Congestive heart failure
- Pneumonia
- Respiratory muscles weakness
- Atelectasis
- Chronic restrictive lung disease

Although some patients with decreased mental status may respond to NIMV, it is desirable that candidates for BiPAP be conscious and cooperative. They should be capable of breathing spontaneously and the gag reflex should be present. The amount of tracheobronchial secretions should not be large, and the gastrointestinal tract should be functioning, in order to avoid gastric distention, vomiting, and aspiration.

Patients with any of the conditions listed in Table 3 could be considered candidates for BiPAP ventilatory support. It appears that patients with hypercarbic failure may be better responders. However, response in hypoxemic failure is also observed.

Once the BiPAP system is chosen, the appropriate mask for the patient should be selected. Soo Hoo and colleagues (14) observed that successful outcome with NIMV depends significantly on patient adaptability to nasal mask and ventilator, so a good fit is essential. In a few institutions, a custom-made mask may be rapidly fabricated. A nasal shell with nasal pillows can be tried for patients who do not tolerate the nasal mask, and mouth-breather patients may do well with a face mask. Continuous reassurance and coaching may also positively affect NIMV tolerance and outcome.

The mode to be used should also be selected. Most of our patients have been ventilated with the spontaneous mode. As a rule, we start with IPAP 8-10 cm H_2O and EPAP 3-5 cm H_2O. Initially, patients are observed very closely, and adjustments for hypercarbia and/or hypoxemia are made as needed. To improve oxygenation, both IPAP and EPAP are increased by 3-5 cm H2O. To increase alveolar ventilation and correct hypercarbia, IPAP is increased by 3-5 cm H_2O. Adjustment in ventilator settings should be made as frequently as necessary, usually every 1/2 to 1 hour.

If no response in clinical condition or gas exchange is observed despite high levels of BiPAP support (IPAP > 20 or EPAP > 15 cm H_2O), endotracheal intubation should be performed and invasive mechanical ventilation instituted without delay.

Precautions

Patients with acute respiratory failure treated with a BiPAP unit should be monitored closely in an ICU, "step-down" unit or similar facility. Blood pressure, EKG, pulse oximetry, and gas exchange should be followed closely.

During treatment with BiPAP, those caring for the patient should be ready to perform endotracheal intubation should BiPAP therapy fail. Patients receiving BiPAP can receive oral medications, however, they should not be fed gastrointestinally if there is significant chance of emergency endotracheal intubation. When using BiPAP, ventilation is better accomplished with the mouth closed, therefore, patients should be advised to breathe through their noses in order to avoid a large leak. Maladjustment and disconnection of the mask is often the cause of BiPAP failure. Patency of nasal passages should be maintained, if necessary with the use of a nasal decongestant. Face mask ventilation should be considered for those patients unable to follow the guidelines already mentioned, as well as for those patients who do not tolerate nasal devices.

Delays from the time that the order is given until BiPAP is implemented can be a serious problem. Availability and familiarity of the health care team with the equipment will reduce the waiting period.

Poor patient selection is another frequent reason for BiPAP failure. Unstable patients who are combative, obtunded or comatose, and those requiring large amounts of sedation and analgesia should not be tried on BiPAP. In addition, patients in whom deterioration of other organ systems is present, and those patients in whom the pulmonary condition leading to respiratory failure appears to be deteriorating are poor candidates to attempt NIMV with BiPAP. Patients with any of the above conditions should be intubated and provided with positive pressure ventilation.

Distention of the stomach, vomiting and aspiration are only occasionally seen. Gastric decompression tubes are not routinely recommended, but patients who develop abdominal distention should have an orogastric or nasogastric tube placed. Other complications such as nasal lesions, conjunctivitis and discomfort with the system are minor problems which frequently may be alleviated with adjustment of the mask.

Conclusion

Non-invasive mechanical ventilation with a BiPAP system has a place in the treatment of acute respiratory failure. Patients with cardiovascular stability and a process whose clinical course is expected to improve or resolve within 24-48 hours are ideal candidates.

A better response to NIMV and BiPAP support is usually obtained with patients with hypercarbic failure rather than hypoxemic failure. During treatment with NIMV, close observation and monitoring are essential.

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Infant/toddler oral health care: Guidelines for the primary care physician

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Abstract

Since primary care physicians treat infants and toddlers on a regular basis, they oversee the growth and development of children and are usually the first health care providers to evaluate their oral health status. When examining an infant or a toddler, certain oral health conditions should be considered, such as tooth eruption, fluoridation, preventive oral hygiene, diet, and orofacial development. This article provides pertinent information in these areas that can serve as a guide for primary care physicians in their routine care of the infant/toddler.

Introduction

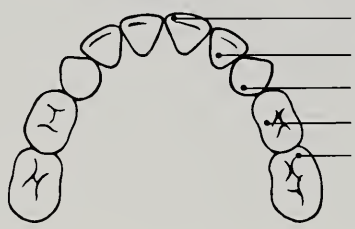
The majority of newborns receive regular medical care during their first few years of life. The physician monitors their overall health by regularly doing a comprehensive infant/toddler examination in which special attention is focused on determining proper fine and gross motor, language, and self-help skills, as well as cognitive and social/emotional development.

The primary teeth are important for chewing, speaking and appearance, as well as serving to maintain adequate spacing for the permanent teeth. Early loss of primary teeth can lead to severe malocclusions and oral dysfunctions. In order to assure optimum health of the oral structures, early preventive care should be initiated. Since primary care physicians treat many children who do not regularly visit the dentist, this article attempts to summarize areas of oral health concerns that are of importance when examining infants or toddlers.

Eruption

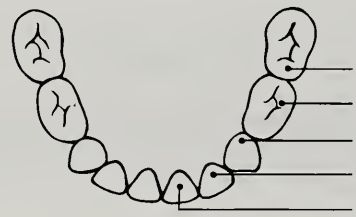
The early years of life are critical in the development of the orofacial structures. The calcification of the primary tooth follicles begins about 3 to 4 months in utero starting with the primary incisors and is complete by the third postnatal month. Disturbances of the calcification process can result in hypoplasia of the enamel forming at that time. Therefore, the primary teeth can be a record of fetal development and provide valuable information on the timing of insults occurring pre-, peri, or early postnatally (1).

Even the normal physiological event of birth is recorded in the enamel and dentin of the primary teeth as a neonatal line (2). Little association, though, has been found between tooth eruption and other stages of childhood development such as height, weight, etc. However,



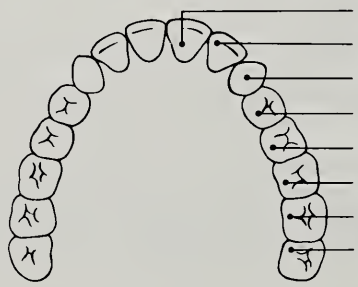
Primary Teeth

Upper Teeth	Erupt	Shed
Central incisor	8-12 mos.	6-7 yrs.
Lateral incisor	9-13 mos.	7-8 yrs.
Canine (cuspid)	16-22 mos.	10-12 yrs.
First molar	13-19 mos.	9-11 yrs.
Second molar	25-33 mos.	10-12 yrs.

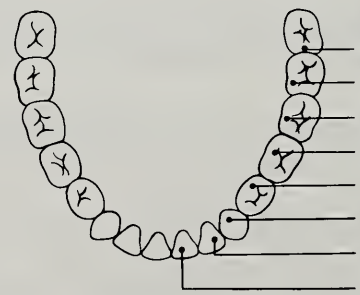


Lower Teeth	Erupt	Shed
Second molar	23-31 mos.	10-12 yrs.
First molar	14-18 mos.	9-11 yrs.
Canine (cuspid)	17-23 mos.	9-12 yrs.
Lateral incisor	10-16 mos.	7-8 yrs.
Central incisor	6-10 mos.	6-7 yrs.

Permanent Teeth



Upper Teeth	Erupt
Central incisor	7-8 yrs.
Lateral incisor	8-9 yrs.
Canine (cuspid)	11-12 yrs.
First premolar (first bicuspid)	10-11 yrs.
Second premolar (second bicuspid)	10-12 yrs.
First molar	6-7 yrs.
Second molar	12-13 yrs.
Third molar (wisdom tooth)	17-21 yrs.



Lower Teeth	Erupt
Third molar (wisdom tooth)	17-21 yrs.
Second molar	11-13 yrs.
First molar	6-7 yrs.
Second premolar (second bicuspid)	11-12 yrs.
First premolar (first bicuspid)	10-12 yrs.
Canine (cuspid)	9-10 yrs.
Lateral incisor	7-8 yrs.
Central incisor	6-7 yrs.

Figure 1. Tooth Eruption and Exfoliation Chart ***"Copyright by the American Dental Association. Reprinted by Permission."***

there has been noted a genetic influence or familial trend with regard to early and/or late eruption (3).

At birth, the crowns of all 20 of the primary teeth are almost completely formed and are present in the jawbones. In addition, the formation of the first permanent molar has already begun.

The entire primary dentition has usually erupted by the second to third year of life. Spacing between primary teeth is common. A lack of spacing could be an indicator that the permanent teeth may be crowded.

By the age of 3, most of the hard tissues in the permanent dentition have already been formed. Thus, injuries to an infant/toddler may result in disturbances in the permanent dentition.

Eruption of the permanent teeth comes later, usually at 6 to 13 years of age. Age of eruption of the permanent teeth is usually more variable than the primary teeth with girls usually ahead of boys. In addition, Caucasians usually erupt at a later age than most races (4).

The first permanent tooth to erupt is the first molar. It erupts posterior to the last primary molar and its eruption is not preceded by the loss of a primary tooth. Parents are many times unaware of its presence. The first permanent molar is the cornerstone of the dental arch and should last a lifetime. An eruption chart of the primary and permanent dentition is illustrated in Figure 1.

Fluoride supplementation

The use of fluorides was probably one of the most remarkable discoveries in preventive medicine/dentistry. By the early 1940s, it was established that .7 to 1.2 parts per million fluoride supplementation of the water supply could reduce cavities in the primary dentition by 40%-50% and permanent dentition by 50%-60% for children drinking fluoridated water from birth (5).

By 1994, however, the fluoride supplementation schedule recommended by the Council on Dental Therapeutics of the American Dental Association, the American Academy of Pediatric Dentistry, and the American Academy of Pediatrics suggested that infants who do not live in areas with a fluoridated water supply should start fluoride supplementation at 6 months of age. The specific recommendations are outlined in Figure 2.

If one is unsure as to whether the water supply is fluoridated in a specific area, the water should be tested for fluoride content. Water from a municipal water supply may or may not contain fluoride, so individuals should contact their local municipal water supply company or the West Virginia Public Health Department to obtain information on fluoride content. Most private water supplies in West Virginia have only traces of fluoride, occasionally more. The West Virginia Public Health Department Fluoride Supplementation Program provides water analysis and fluoride supplements free of charge. Physicians can enroll in this program and receive these services.

The prevalence of dental fluorosis has increased since the 1940s in both fluoridated and non-fluoridated communities because of the increased exposure to systemic fluorides. Fluorosis can range from mild, which consists of a few white opaque areas on the enamel, to tan, brown, and almost black spots with mild to deep pitting (6).

The very mild forms are of no consequence. However, more severe levels can be an esthetic concern and may threaten the use of systemic fluoride to prevent dental decay. Sources of fluoride are drinking water, fluoride supplements, diet, and inadvertent ingestion of toothpaste by young children. Thus, it is important to prescribe proper dosages of fluoride supplementation when fluoride is not found naturally in the drinking water.

A fluoride dentifrice is another important element in cavity prevention. Studies have shown a large variability in the amount of toothpaste ingested by young children (7), so it is important to advise the parents of young children who tend to swallow toothpaste to use the fluoride toothpaste sparingly (i.e. just enough to wet the end of one tuft of the bristles). Currently, toothpastes with fluoride display warning labels on their packages for children under six years of age.

In spite of the already accepted therapeutic effect of systemically-ingested fluoride, prenatal fluoride supplementation is still a controversial issue. Research studies have shown that fluoride does pass the placental barrier in pregnant women and is stored in the placenta. However, the clinical and statistical evidence supporting the benefit of prenatal fluoride supplementation is inconclusive. At this time, the American Academy of Pediatric Dentistry does not support the administration of prenatal vitamins containing fluoride (8).

Plaque control

In general, the first primary tooth erupts around 6 months of age. This initial eruption time varies. Parents should be encouraged to clean the teeth as soon as they erupt because a film of bacteria called plaque forms on the teeth, which in the presence of sugars and or starches, can lead to tooth decay. Plaque removal is usually done with a wet washcloth, but as more teeth erupt, a small infant size soft bristle toothbrush can be used. It is important that the parent continue with daily oral hygiene so the child is accustomed to daily oral manipulation. The child should never be left with a toothbrush unsupervised to prevent a possible choking accident. The parent should take responsibility for brushing the child's teeth until the child is old enough and displays the dexterity to brush on his/her own. Even then, a child should be supervised up to 9 to 10 years of age.

Teething in young children can sometimes be painful, and in some instances, the gums may become swollen. There can be excessive

Figure 2. Dietary Fluoride Supplementation Schedule in mgF/day*

AGE OF CHILD	WATER FLUORIDE CONCENTRATION (PPM OR MG/L)		
	≤ 0.3 ppm	0.3 ppm to 0.6 ppm	> 0.6 ppm
6 months-3 years	0.25 mg	0	0
3-6 years	0.50 mg	0.25 mg	0
6-16 years	1.0 mg	0.50 mg	0

*1994 Recommendations by the Council on Dental Therapeutics of the American Dental Association, The American Academy of Pediatric Dentistry, and the American Academy of Pediatrics.

drooling, and general malaise. Treatment for teething is symptomatic i.e., proper dosage of acetaminophen, chilled or unchilled teething toys, and/or digital massage.

Dietary concerns

When food containing refined carbohydrates and particularly simple sugars such as sucrose is eaten, concentrated acid is built up around the teeth. If teeth are not clean, the acid works on the plaque and starts to break down the teeth. The strongest evidence linking intake of sugars to high cavity rates is the frequency of consumption such as between meal snacking (9), so early dietary counseling is helpful.

Limiting the child to two snacks a day may be helpful, and non-sugar snacks are the best. If teeth are clean, the decay process cannot occur in spite of the sugar consumed. Parents should be advised that the child should never be put to bed with a bottle containing anything but water. In addition, the bottle should not be used as a pacifier.

When the bottle is used as a pacifier, especially when an infant/toddler is put to sleep with the bottle, the sugars from the formula, juice, etc., pool on the teeth and can lead to rampant decay of primary teeth. This condition is referred to as nursing bottle caries or baby bottle tooth decay, and it can develop within a few weeks after the eruption of the primary teeth.

The child can develop an infection from the carious teeth. This condition is clearly related to the habit of using the bottle as a pacifier or nursing from the bottle or breast for extended periods of time. Thus, nursing bottle caries has been found to run in families. It is important to review the family history of decay and infant feeding practices. This situation can be prevented with early intervention to promote good oral hygiene and proper feeding habits.

Orafacial development

In assessing normal and abnormal orofacial development, the first step is to ask the child to bite the back teeth together, and hold the position while you are facing him/her. Teeth in general reflect the skeletal relationships and help in identifying possible jaw disharmony.

If the top teeth come together behind the bottom teeth (Figure 3), the child has an underbite or a Class III malocclusion. Often, this is due to the upper jaw which is too far back or too small, or the lower jaw which is too far forward or too large. This condition occurs in about 1%-5% of the Caucasian population, but 14% in Asians. Early orthodontic treatment is helpful in promoting proper orofacial growth and development, and treatment can usually be initiated at 4 to 5 years of age.

More frequently, though, the upper teeth are more than 3-5 mm in front of the lower teeth. This is a Class II malocclusion or an overbite. This type of malocclusion occurs in 15%-20% of the population, and these problems are usually addressed during the child's maximum growth period or a few years before puberty.

Occasionally, the top side teeth on one or both sides are inside of the bottom teeth (Figure 4). This is a significant problem called a crossbite and it occurs in 5% of the population. Generally, the upper jaw is too narrow, and children with this type of problem sometimes shift their jaw to one side because their teeth do not occlude well. This type of problem should be addressed immediately since crossbite with a jaw shift could lead to asymmetric jaw growth.

Another childhood dental problem that can develop is an openbite or spaces between the front teeth. This occurs in children who have a persistent thumb or digit habit, so it is critical that children be discouraged from sucking their fingers or pacifiers when they are four years or older. In most cases, when the habit is stopped, the teeth will erupt together. If these habits are not discontinued with oral instruction, the parent should consult their pediatric dentist for an appliance to help.

Conclusion

Oral health of infants/toddlers should be a very important concern for primary care physicians. Children in West Virginia have a rate of loss of first permanent (six year) molars that exceeds any other state (10).

Primary care physicians in West Virginia are critical in the overall Public Health mission which includes providing a positive environment for the development of optimal oral health. Identification of the problems described and their appropriate management or referral will significantly improve the oral health of the children in our state.

Figure 3. A 5-year-old patient with an underbite or Class III malocclusion due to undergrowth of the upper jaw.

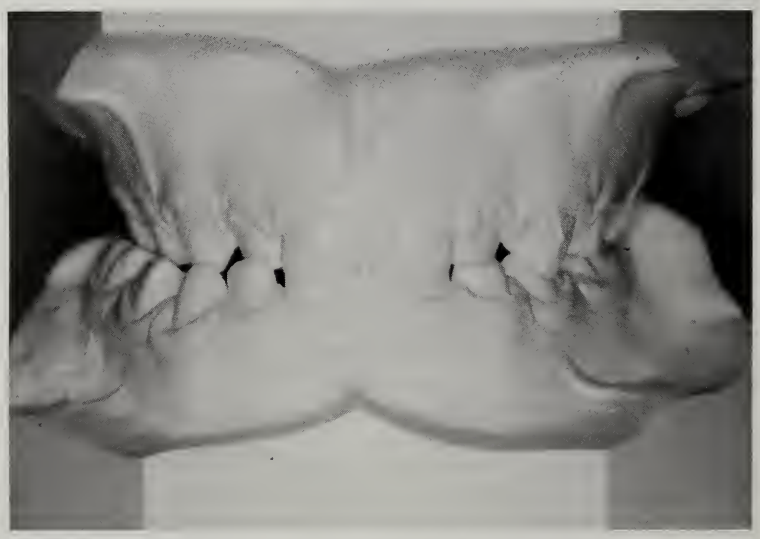


Figure 4. A 4-year-old patient with a crossbite. Note the top side teeth and patient's right side is inside of the bottom teeth.

Acknowledgements

We would like to thank Dr. Christina B. Debiase for her careful review of this manuscript, and extend our appreciation to Karen Thorn for her technical assistance.

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Late solitary cerebral metastasis from renal cell carcinoma: A case report and review of the literature

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Abstract

Metastatic disease to the brain occurs in 5%-10% of cases of renal cell carcinoma (RCC). Solitary involvement of the brain is less common with a reported incidence of 0.6% - 2.5% in large autopsy series. In a review of the literature, only five cases of solitary brain metastasis from RCC with a latency period greater than 10 years have been documented. In this article, we report the case of an 86-year-old white female who developed a brain metastasis 15 years after nephrectomy. As a result of our experience with this patient and a review of the literature, we conclude that in patients with a history of RCC, metastatic lesions from the primary tumor must remain in the differential when evaluating any subsequent brain lesion, as metastases may appear well over a decade after nephrectomy.

Introduction

Renal cell carcinoma (RCC) has an incidence of 7.5 per 100,000 population in the United States with approximately 26,000 new cases diagnosed and 10,700 deaths annually (1). Of these patients, 25% will have metastases at the time of presentation, and an additional 30% will develop metastases sometime during the course of their disease (2). The incidence of clinically evident solitary metastases is reported to be approximately 2%-3%. This figure increases to 8% when autopsy series are considered (4).

McNichols et al reported that 11% of patients with RCC have a late recurrence (i.e. more than 10 years after nephrectomy)(5). Metastatic lesions from RCC appearing greater than 15 years after nephrectomy have been described in the lung (6), bone (5), pancreas (7), thyroid (8), liver (9), nephrectomy scar (10) and jejunum (11).

In this article, we describe the case of a solitary brain metastasis from RCC 15 years after nephrectomy and review the literature.

Case report

An 86-year-old white female was admitted to Charleston Area Medical Center with a three-month history of confusion and depression. The physical examination on admission was remarkable for right hemiparesis and mild expressive aphasia. A brain computerized tomographic (MRI) scan revealed a contrast-medial-enhanced large cystic lesion involving the left frontal lobe associated with a shift of midline structures from left to right and diffuse cerebral edema.

A craniotomy was subsequently performed which revealed a cystic, vascular tumor. Only a partial debulking could be performed though because of excessive bleeding from the tumor. This patient had modest clinical improvement (i.e. increased level of alertness, less confusion) postoperatively. She had undergone a right nephrectomy for RCC 15 years previously, but no apparent metastatic lesion was observed at that time.

Pathological examination of the brain tumor revealed a clear cell adenocarcinoma. The histology was the same as the original kidney neoplasm. Postoperatively, a CT-scan of the chest and abdomen and bone scan revealed no evidence of metastasis. Unfortunately, she deteriorated neurologically after her hospital discharge and expired six weeks after diagnosis.

TABLE 1. Cases of Late Solitary Cerebral Metastases Which Developed More Than 10 Years After Renal Cell Carcinoma

AUTHOR	SEX	AGE	TIME FROM NEPHRECTOMY TO BRAIN METSASTASIS	PRESENCE OF EXTRACEREBRAL METS	PRESENT STATUS
Ammirati et al	F	63	13 years	No	Alive 18 months without disease
Middleton et al	M	–	13 years	No	Alive 14 years without disease
Killebrew et al	F	55	14 years	No	Alive 17 years without disease
Radley et al	78	18	Less than 1 year		Alive one year without disease
	F	60	15 years	No	–
Ishikawa et al	F	81	14 years	No	–
Present Report	F	86	15 years	No	Died 6 weeks after surgery

Discussion

The brain is not a common site for RCC metastases since this condition occurs in 3.9%-24% of cases (12-14). Solitary involvement of the brain is less common. In an autopsy study of 1,828 patients with RCC, Saitoh and colleagues (15) reported 177 cases (9.7%) with brain metastases of which the brain was the sole site of dissemination in 12 cases (0.66%). In addition, O'Dea et al (16) reviewed 1,761 autopsy cases of RCC and found the solitary metastatic rate to the brain to be 2.5%.

The interval between the diagnosis of RCC and the development of brain metastases ranges from 0 to 10 years with a median value of seven years (3,17). However, the median interval was slightly greater than 12 months in the two largest series reported (13,17); and almost all patients had evidence of disseminated disease at the time the brain metastases were diagnosed. As noted in Table 1, only seven cases have been reported of a solitary brain metastasis more than 10 years after the diagnosis of RCC (18-22). The time period from nephrectomy to the diagnosis of brain metastases ranged from 13-18 years. None of these patients had extra cerebral metastases at the time of diagnosis. As of April 1995, five of these patients had survived at least one year (range 1-17 years).

RCC is thought to spread to the central nervous system via the pulmonary arterial circulation (23) or by passage of tumor cells into the spinal epidural plexus and vertebral veins as described by Batson (24). It is not known why some renal cell carcinomas remain silent for long periods of time. Immunologic mechanisms and the inherent slow growth of the tumor have been suggested to explain the occurrence of late metastases (25,26).

Physicians generally warn patients of a poor prognosis if there is an appearance of brain metastases from RCC. Decker and colleagues (27) reported a mean survival of three months and eight months in untreated and radiotherapy-treated patients respectively. In selected patients with a solitary metastatic lesion, surgical excision ± radiotherapy may result in prolonged survival, and radiosurgery with the gamma knife has been reported to shrink a recurrent solitary RCC metastasis (28). To date, chemotherapy and immunotherapy have yielded poor results.

Metastatic disease should be considered in all patients with prior resection of RCC who experience neurologic symptoms, metastatic lesions, particularly if such a lesion appears after a prolonged disease-free interval.

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Endometrial cancer: Risk factors and diagnosis

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Abstract

Endometrial cancer occurs more frequently than any other cancer of the female reproductive tract. The overall five-year survival rate for patients with endometrial carcinoma in a series of 13,000 patients was 68%. If diagnosed with Stage I disease, the patient's five-year survival increases to 75% (17). Early diagnosis of uterine cancer is accomplished by physician recognition of risk factors, symptoms and signs.

Introduction

Endometrial cancer occurs primarily in postmenopausal women. Since all women are not followed by gynecologists, primary care physicians need a clear understanding of this disease as well as endometrial hyperplasia, which is considered a risk factor for endometrial cancer.

This paper will review epidemiology, histology, risk factors and symptomatology, and methods for endometrial biopsy.

Epidemiology

Endometrial cancer is the fifth most common cancer of women in the world (6.7 cases/100,000 females/year), and the fourth most common cancer of women in North America (25.5 cases/100,000 females/year) behind breast, colorectal and lung (1). According to 1992 estimates, there were 32,000 new cases of this disease and 5,600 deaths (2).

From 1935 to 1970, the incidence of uterine cancer was stable at about 19 cases per 100,000 females per year (3). In the early 1970s, the incidence of cancer of the uterine corpus increased to a peak incidence of 30/100,000. This increase was thought to be the result of unopposed estrogen for hormone replacement therapy between 1960-75 (4).

Both Zeil in 1975, and Mack in 1976, reported that estrogen replacement therapy was associated with endometrial cancer (5); and in 1979, Gambrell reported that the addition of progestin to estrogen reversed the carcinogenic effect of estrogen. Following these landmark studies, the use of unopposed estrogen declined (6), and the incidence of uterine cancer declined between 1977 and 1989 to 21.1 cases per 100,000 (7).

The median age for the diagnosis of endometrial carcinoma is approximately 60 years (8). Only 1% of women with uterine cancer are under the age of 40 years and only 7% are under the age of 50 years (9). Since the average age of menopause is 50 (10), it is apparent that most women with uterine cancer will be postmenopausal.

Histologic types

A variety of neoplasms may originate in the endometrium, and the greatest percentage of all cancers are adenocarcinomas. A study of 1,009 cancers evaluated at the Institute of Pathology of the University of Cleveland revealed the percentages listed in Table 1 (11).

Risk factors

The major risk factor for endometrial carcinoma is unopposed estrogen stimulation of the endometrium which also produces hyperplasia (4). Atypical endometrial hyperplasia, considered a premalignant lesion, may take five or more years to progress to adenocarcinoma (12).

Increased unopposed estrogen occurs in obesity (13), polycystic ovary disease, chronic anovulation (14), estrogen producing ovarian tumors (15), and hormonal replacement therapy. Tamoxifen, which has both estrogenic and antiestrogenic effects, has been associated with an increased risk of endometrial carcinoma (16). Other associated conditions are hypertension, diabetes, nulliparity, and late menopause (12).

In contrast to cervical cancer, malignant tumors of the corpus are nearly two times more frequent in white women than in black women in the United States. This can be expressed as the risk at birth of eventually developing corpus cancer: 2.4 for white women versus 1.3 for blacks (4). Since women who smoke have diminished estrogen levels and have earlier menopause than those who do not, it has been suggested that smoking decreases the risk of endometrial cancer (4).

Symptoms

Post menopausal bleeding and abnormal perimenopausal bleeding are the primary symptoms of endometrial cancer (17). Other symptoms include vaginal discharge and pain. In addition, 1% of patients will be asymptomatic (Table 2) (19).

Table 1. Histology of Uterine Cancer

Adenocarcinoma	65%
Adenoacanthoma	19%
Adenosquamous carcinoma	14%
Clear cell	1%
Secretory adenocarcinoma	1%
Other (squamous, metastatic)	< 1%

Table 2. Uterine Cancer Symptoms

Bleeding	80%
Discharge	10%
Pain	5%
Bleeding & Discharge	1%
None	1%

Endometrial hyperplasia

Hyperplastic growth of the endometrium is a risk factor for endometrial cancer. Although considered a pre-malignant change, some of these lesions revert to normal either spontaneously or with medical therapy. Some lesions persist as hyperplasia, and a few progress to endometrial adenocarcinoma (17).

In the 1950s, Gusburg and Kaplan performed a prospective study on approximately 400 patients with postmenopausal bleeding. One half or 191 patients had adenomatous hyperplasia on initial curettage specimen; the control group had no hyperplasia or carcinoma on initial curettage. Ten year follow-up showed 30% cumulative risk for cancer in the patients with endometrial hyperplasia (5).

Most endometrial hyperplasia is thought to result from persistent, prolonged estrogenic stimulation of the endometrium (17). Historically, many classification schemes existed for endometrial hyperplasia. Many were poorly defined, resulted in poor reproducibility, and failed to provide a rational approach to patient care.

In an attempt to provide more precise definitions for endometrial hyperplasia, the International Society of Gynecological Pathologists has proposed new terminology for both morphology and natural history of the lesion (8). Hyperplasia is differentiated from normal proliferative or secretory endometrium, endometrial polyps and cystic atrophy (8). These latter lesions have no malignant potential.

The hyperplasias are divided into those with atypicality and those without. Each of these is then further subdivided into simple or complex with the major differing features being complexity and crowding of the glandular elements (5). Criteria for cytologic atypia include large nuclei of variable size and shape that have lost polarity, increased nuclear to cytoplasmic ratios, prominent nucleoli, and irregularly-clumped chromatin with parachromatin clearing.

Cytological atypia seemed to be the best indicator for higher risk of progression to carcinoma (8). Kurman studied endometrial currettings from 170 patients and found that progression to carcinoma occurred in 1% of those patients with simple hyperplasia; 3% in patients with complex hyperplasia; 8% in patients with simple atypical hyperplasia and 29% in patients with complex atypical hyperplasia (4).

The hyperplastic process may be generalized throughout the endometrial cavity or localized to one or more areas. In patients with atypical hyperplasia in a curetting specimen, approximately 25% will have an associated well-differentiated carcinoma if a hysterectomy is performed (8). Hyperplasia may occur in any age group, and it is occasionally seen in teenage patients who have intermittent progesterone production and persistent estrogen stimulation without ovulation. In a similar manner, it is commonly observed during menopause, when the process of ovulation is inconsistent (5).

The diagnosis of endometrial hyperplasia as well as endometrial cancer requires pathologic examination, but there is no consensus regarding screening for either diagnosis. The American Cancer Society advocates endometrial biopsy in high-risk women at menopause, however, the Canadian Task Force and the International Union Against Cancer do not (12). Hall and colleagues stated "Despite the controversy over screening for endometrial cancer ... endometrial sampling of those women considered high risk would seem prudent" (12).

Since abnormal bleeding is the main symptom for both endometrial hyperplasia and endometrial cancer, all women with abnormal bleeding and especially bleeding after menopause should undergo endometrial biopsy (8).

Techniques

In 1843, Recamier proposed the use of a small scoop attached to a long handle for removing intrauterine fungal growth he believed to be a cause of metrorrhagia. He called this procedure a curettage and later reported three deaths from its use as a result of perforation and subsequent peritonitis.

It was not until early in the 1900s when antiseptics were available that curettage became an accepted procedure for the diagnosis of endometrial pathology. Dilatation and curettage (D & C) as it became known was soon the most common operation performed on women in the world (18).

In 1970, the vacuum curettage was introduced for use in the office. The feasibility of using this instrument without anesthesia was shown in a series of 350 patients 17-90 years of age who were referred for irregular uterine bleeding. Adequate histologic tissue for diagnosis was obtained in 98.5% of the specimens with minimal complications (18), and compared to the D & C was one tenth the cost. This was the initial report on the use of what later was to become the Vabra aspirator.

Today, many instruments are commercially available for sampling the endometrial cavity. They differ primarily in the method by which suction is produced to obtain a specimen (19). Several studies have demonstrated that the accuracy of office-based biopsies in detecting endometrial cancer is approximately 90% (5).

The type of instrument used to sample the endometrium should be based on physician experience and cost. A D & C should be reserved for those patients in whom inadequate tissue for evaluation was obtained by the office procedure, those patients in whom the procedure cannot be performed for technical reasons, or those patients in whom the exam under anesthesia will contribute to the diagnosis and management of the problem (4). In addition, outpatient endometrial sampling should not be considered when there is cervical stenosis, acute pelvic inflammatory disease, pregnancy or bleeding disorders (18).

Transvaginal ultrasound has recently been proposed for the diagnosis and management of abnormal bleeding. Its usefulness is in determining the thickness of the endometrium. A recent study by Goldstein (20) showed that less than 5 mm of endometrial thickness correlated 100% with insufficient tissue for diagnosis on endometrial biopsy. Conversely, those women with greater than 5 mm tissue by transvaginal ultrasound often had abnormal pathology on subsequent biopsy. This study raises the possibility that a decision to proceed with endometrial sampling may be modified using transvaginal ultrasound (18).

The Papanicolaou smear, used for cervical cancer screening, has an unacceptably high false negative rate for detecting endometrial cancer and therefore should not be relied upon for diagnostic purposes (8).

Conclusion

Uterine cancer is a disease of postmenopausal women. Internists and all primary care providers need to be aware of the risk factors, the most important of which is unopposed estrogen stimulation to

the endometrium. All women with post-menopausal bleeding need endometrial evaluation.

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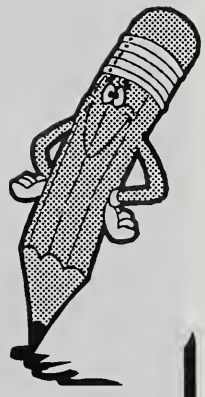

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President's Page

Make the most of 1996

Each January there seems to be a long-standing tradition of reflecting on the year just passed and anticipating what the new year will bring.

Just as it began, 1995 concluded with an influx of managed care into the state. West Virginia is one of the last states to begin its journey toward a mature managed care market. While it remains to be seen what modifications corporate medicine must make in a rural state that runs on minimal revenue, physicians should remain alert and watch for the early, subtle warnings that occur in advance of major events. The WVSMA, in conjunction with other state and national organizations, continues to scan the horizon of managed care. "Weather reports" are provided regularly in *WESGRAM* and the *Journal*.

The start of 1996 also signifies the second year that the WVSMA has endorsed Medical Assurance of West Virginia, Inc., as its liability insurance carrier. This company has an A+ bond rating coupled with an aggressive defense posture providing the practicing physician with as much support as possible in malpractice defense. With appropriate underwriting standards, Medical Assurance can continue to provide quality liability insurance for West Virginia physicians just as the company does in 12 other states. Medical Assurance has its roots in Alabama, where 20 years ago frustrated, hard-working physicians (sound familiar?) joined together to create their own insurance company. We are fortunate in this state to have Medical Assurance as an option for liability insurance coverage.

As with most other issues in West Virginia, politics plays a major role in our lives. No where else is more attention paid to the opening of the Legislature than here in West Virginia. In 1995, we saw the passage of a Medical Savings Account law. Even though there were forces out to sink this legislation before it was passed, common sense prevailed. Despite the fact that most legislators enter the Capitol building with good intentions, the political process sometimes seems to distort human behavior under that gold dome. Our legislators hear us when we send them messages, which can be in the form of letters, personal phone calls, the Alliance Legislative Phone Bank, personal contributions, WESPAC contributions, and direct visits during the session. Due to an increase in physician involvement in state and national political affairs, we saw positive changes last year. I'm convinced this was not a fluke, but rather the early stages of a trend toward more physician involvement in the political process.

Doctors in surrounding states are on the same track. Several states have adopted our $365 or Dollar-a-Day concept for PAC contributions. Currently, 83 members belong to the $365 Club. That's up from 64 members four months ago. With political races for governor, state Senate, U.S. Senate, House of Delegates and State Supreme Court coming in 1996, there appear to be many openings for West Virginia physicians to become involved.

To those of you who always complain that doctors are always on the outside looking in, I ask you to look at this election year very, very seriously. We have a number of opportunities to make the kind of changes that we want. Let's make the most of them!

James D. Helsley, M.D.

Doctors join protest

It was just a small, easily missed newspaper caption on a short story noting, *"Doctors Join Protest."* The story very briefly observed that about 2,000 doctors in France held a protest in association with the multitude of shutdowns, strikes, protests, job actions, and riots recently fomented in that country over government austerity plans to curtail various entitlements and other generous benefits bestowed in previous years by the French welfare state.

It's not often one hears of protests or group actions by doctors in any country. As a matter of fact, we are hard pressed to name even a single instance of such beyond a generalized chorus of intermittent grumbling from medical groups in our own and many other countries. Mostly doctors are long-suffering, rather passive and accepting of their lot in the scheme of things. It must be acknowledged that our lot has not been all that bad for the past 30 or 40 years or so but still, it is the experience of those good years to which we have become accustomed that makes it so difficult to accept something less.

The non-monetary rewards of Medicine -- patient respect and gratitude, community status and the certitude that one is daily doing something useful, highly regarded and even romantic -- are probably the things that have contributed to the absence of militancy among doctors while intrusive thrusts are made into our realm by HMOs, insurance companies, government and other such pests. The courts and plaintiff attorneys have also outdone themselves in devaluing these non-monetary rewards, but have failed to negate them entirely. The satisfying nature of our work continues to induce us to simply yearn to be left alone.

French doctors cannot be that much different from their American colleagues. What does it take then to induce 2,000 French doctors to stage a protest in association with other wild demonstrations held by essentially alien occupational groups? The French, of course, are renowned for easy arousal to heights of emotional passion on more than one subject. But, French doctors have not heretofore been a part of the demonstration scene. To our knowledge, French medical groups do not promote themselves as unions whose leaders and organizers, as in any union, would have the principal job of keeping its members unhappy.

We are not intimately familiar with the workings of the French medical care system, but we understand from contacts with others more familiar with that system that neither the doctors nor their patients have been particularly unhappy with the system over the years of its development. That same outlook on affairs seems to have pervaded French culture and society generally as they have responded to the generosity of the welfare and security-oriented socialist government. And why would one expect the French or any other nationality to be anything but pleased and complacent when the government or any other entity is giving them something apparently for free or at bargain rates?

We suspect the answers to the questions posed carry ominous warnings to American Medicine and to the American public. It is easy to be lulled into complacency and unwariness by government "gifts." That is what seems to have happened to French Medicine in concert with the remainder of French society. French doctors allowed themselves to enjoy the drug of government support along with their brotherhood of French labor groups. Now, with their new brothers they suffer withdrawal pains.

French doctors allowed themselves to be bought by government largesse in years past. Now, the government pot is near empty. French taxes have been making that nation economically non-competitive. The government drug high is over for all of them and it is time for a little suffering.

What will it take to make some number of thousands of American doctors demonstrate with other Labor militants? Have we already left our professionalism behind us or are we just edging in the direction of joining our Labor brothers on the picket line?

We have already been tempted by some apparently attractive blandishments of insurance goliaths and our federal government. Before the passage of very many more months we will be tempted even more. Let us hope we will not succumb and reduce ourselves to the plight now faced by our French colleagues.

Stephen D. Ward, M.D.
Editor

Special Correspondence

Dear Colleagues:

You have recently received your first bill for dues for the AMA, WVSMA and in some instances, your county society dues. Please note the opportunity to contribute to WESPAC. I urge both you and your spouse to contribute, preferably at the $365 level for yourself and an additional contribution for your spouse.

Why should you be in WESPAC?
You should be a member because WESPAC has been working hard on your behalf even though this is not an election year. Our membership in 1995 was 273 out of approximately 2,500 potential WVSMA members, with 83 at the Dollar-A-Day level. Our total contributions for 1995 were $42,000, which is twice as much as in any election year prior to 1994. Some of us are really contributing, but we need the help of more of you.

What is WESPAC doing NOW?
We are surveying all the gubernatorial candidates as to their positions/solutions to Medicaid, Workers' Compensation, tax credits and other matters of concern to us. The results of the survey will be published in the *West Virginia Medical Journal*. We are also inviting them to a debate on medical topics in Charleston, tentatively scheduled for February 10. In September, we hope to repeat this debate between the two primary winners.

We have been wrestling with the question of endorsing a candidate/candidates in the gubernatorial race. Neither WESPAC nor the WVSMA has ever done this in the past. However, there is no reason not to if YOU, the MEMBERSHIP, feel that it is worth the effort and risk. If you want to know more, please attend the WESPAC meeting during the Mid-Winter Seminars and Scientific Conferences in Charleston on Friday, January 20 at 4 p.m. All members are welcome and encouraged to attend.

We believe that WESPAC did make a difference in a number of races in 1994 and we want to be more effective in 1996. Thanks to our efforts in the elections, our representatives at the WVSMA had much better access to, and influence on the Legislature in 1995. And don't forget, all 100 members of the House of Delegates and half of the Senate will be up for election in 1996 as well. Please begin to make yourself aware of who is planning to run since we will need your input in these endorsements.

To continue this success, we need your financial support as never before. **PLEASE JOIN WESPAC!!**

Sincerely,

Douglas E. McKinney, M.D.
WESPAC Chairman

Mark these dates!

Legislative visits at the Capitol

January 25, 1996
February 14, 1996 - *Legislative Reception*
February 29, 1996

On all three occasions we will meet at 9:30 a.m. at the WVSMA office, for a brief update before leaving for the capitol. A shuttle bus runs all day to and from the parking area and capitol. (Directions will be given out at the WVSMA office). On February 14, the annual Legislative Reception will be at the Marriott that evening at 5:30 p.m. For more information about the Legislative visits or Reception, please call 1-800-257-4747.

Please plan to come!

At Mid-Winter

Rockefeller to be among panelists for Physician/Public Session on tort reform

Rockefeller

Helsley

Chambers

Sensabaugh

Reynolds

"Tort Reform and Product Liability Legislation" is the topic for this year's Physician/Public Session, which will take place on Friday, January 19 from 7 p.m. - 9 p.m. during the WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences at the Charleston House - Holiday Inn.

Guest speakers for this session will include **Senator John D. "Jay" Rockefeller IV; Robert "Chuck" Chambers, J.D.,** speaker of the West Virginia House of Delegates; **Don Sensabaugh Jr. J.D.,** general counsel for the WVSMA; and **William A. Reynolds, M.D., F.A.C.P.,** a regent of the American College of Physicians. In addition to being a panelist for this session, **Senator Rockefeller** will also serve as a moderater with **WVSMA President Dr. James Helsley**.

The public is encouraged to attend this free event and CME for physicians and CEU credit for RNs and LPNs is being offered through CAMC. Bios on the panelists for this session begin below, and a registration form for the meeting is on page 40. For more details, phone the WVSMA at (304) 925-0342.

Speakers highlighted

Senator Rockefeller graduated from Harvard University in 1961 with a B.A. degree in Far Eastern languages and history. He also studied Japanese language at International Christian University in Tokyo for three years and Chinese language at Yale.

In 1964, Rockefeller came to West Virginia to serve as a VISTA worker in Emmons and decided to make the state his home. Elected to a two-year term in the West Virginia House of Delegates in 1966, Rockefeller served four years as secretary of state, three years as president of West Virginia Wesleyan College, and eight years as governor before being elected to his current role as a U.S. Senator.

During his years in Congress, Rockefeller has focused on jobs, health care, support for education and literacy, economic development assistance, worker training, veteran benefits, and access to air and rail transportation. In 1989, he authored legislation to reform the way physicians are paid under Medicare, and his legislation to expand Medicaid to cover home and community health care services was approved by Congress in 1990.

Since he was elected to the Senate, Rockefeller has held many leadership roles including serving as chairman of the BiPartisan Commission on Comprehensive Health Care (the Pepper Commission), and currently he is chairman of the Subcommittee on Medicare and Long-Term Care; the Subcommittee on Health for Families and the Uninsured; the Subcommittee on International Trade, Foreign Commerce and Tourism; the Subcommittee on Surface Transportation; and the Subcommittee on Science, Technology and Space. In addition, Senator Rockefeller is chair of the National Commission on Children, and serves as a member of the Senate Steel Caucus and the Senate Steering Committee on Democratic Policy.

Chuck Chambers earned a B.A. degree in political science from Marshall University and a doctor of law degree from WVU. After obtaining his J.D. degree in 1978, Chambers was elected to the West Virginia House of Delegates, where he has served as speaker since 1987.

During his career in the House of Delegates, Chambers has been a member of the Judiciary Committee and was appointed chairman in 1985. Other House positions he has held include chairman of the Joint Committee on Legislative Rule-Making Review and vice chairman of the Select Committee on Redistricting.

An attorney with offices in Huntington and Charleston, Chambers serves on the Board of Governors of the West Virginia Trial Lawyers and is a member of the Executive Committee of the National Conference of State Legislatures. He is married to Sonia Daugherty, who is assistant to the dean of the Marshall University School of Medicine.

Don Sensabaugh is a native of Parkersburg who holds a doctor of jurisprudence degree from WVU, where he received the Corpus Juris Secundum award for significant legal scholarship. He graduated in the top 10 percent of his law class and was also associate editor of the *West Virginia Law Review.*

Sensabaugh has practiced law in Charleston for nearly 20 years and is a partner in the law firm of Flaherty, Sensabaugh & Bonasso, which he helped to form. He specializes in the defense of medical and hospital malpractice suits and health care law.

A charter member of the Defense Trial Counsel of West Virginia, Sensabaugh is a member of the American, West Virginia and Kanawha County Bar Associations. He is also a member of the American Society of Law and Medicine and the National Health Lawyers Association.

Sensabaugh's clients include West Virginia Hospital Insurance Company, Medical Assurance of West Virginia, Inc., St. Joseph's Hospital of Parkersburg, Princeton Community Hospital, West Virginia University Hospitals Inc., and the WVSMA. He is a board member of the West Virginia Board of Physical Therapy.

Dr. Reynolds is a native of Montana who received his M.D. degree at Washington University in St. Louis in 1956. After finishing his internship at University of Minnesota Hospital, Dr. Reynolds completed a fellowship in internal medicine at the Mayo Clinic from 1957-59.

Following his fellowship, Dr. Reynolds joined the U.S. Air Force Medical Corps and served for over two years at the Air Force Hospital in Morocco. After his military service, he continued his postgraduate studies in internal medicine at Mayo, where he received an M.A. degree in medicine in December 1964.

Shortly before he received his degree from Mayo, Dr. Reynolds joined the staffs of the Western Montana Clinic and the Saint Patrick Hospital and Community Hospital in Missoula, Montana, where he worked until 1993. For the past three years, Dr. Reynolds has been practicing endocrinology on a part-time basis at Western Montana Clinic, and since May 1995 he has been the co-investigator in a clinical trial by the University of Washington in Seattle and Boehringer Mannheim on the use of Ibandronate in postmenopausal women with osteoporosis.

A member of the American College of Physicians since 1969, Dr. Reynolds was advanced to fellowship in 1971, and is currently president-elect. Dr. Reynolds is certified by the American Board of Internal Medicine and is treasurer and a board member of Action in Internal Medicine, Inc. During his career, he has had articles published in *JAMA, New England Journal of Medicine, Annals of Internal Medicine, Cancer, Medicine,* and *Rocky Mountain Medical Journal.*

At Mid-Winter

Fourth Scientific Session to challenge participants with *"Stump the Audience"*

The Fourth Scientific Session which highlights a *"Potpourri of Topics,"* will this year conclude with a segment entitled *"Stump the Audience,"* at the WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences at the Charleston House - Holiday Inn. Set for Sunday, January 21 at 9 a.m., this session will feature CME and CEU credits and will be moderated by **Daniel S. Foster, M.D.**, chairman of the WVSMA's Mid-Winter Clinical Conference Committee.

Harris

Ledet

Marshall

Point

The first topic to be discussed will be *"Molecular Biology and the Diagnosis of Disease,"* which will be presented by **Charles L. Harris Jr., Ph.D.**, professor of biochemistry at the WVU School of Medicine in Morgantown. Following Dr. Harris' lecture, **Walter P. Ledet Jr., M.D.**, of Sulphur, La., will address *"Day Surgery Without Disability and Expanding List Sans Laparoscopy."*

After a break, the session will reconvene with the Stump the Audience segment, which will be facilitated by **Robert J. Marshall, M.D.**, a clinical professor of medicine for both WVU and Marshall University, and **Warren Point, M.D.**, of Charleston. The special guests for this session will include **Patrick L. Brown, M.D.**, director of cardiology laboratories at St. Mary's Hospital in Huntington; **Richard D. Layne, M.D.**, a professor of medicine at WVU; and **Alfred K. Pfister, M.D.**, clinical professor of medicine at the Charleston Division of WVU. These three physicians will each present a case study, giving parts of the medical history with audience involvement, then presenting physical findings and laboratory and other data as requested by participants before inviting them to make the diagnosis. Each speaker will conclude with comments about the disease process in question.

Brief bios on Drs. Harris, Ledet, Marshall, Point, Brown, Layne and Pfister begin on the following page. As stated on the opposite page, a registration form for the Mid-Winter meeting appears on page 40 and more details about the conference can be obtained by phoning the WVSMA at (304) 925-0342.

Facilitators/faculty highlighted

Dr. Harris was born in Chicago and received his B.S. degree in chemistry and his Ph.D. in biochemistry from the University of Illinois.

After earning his Ph.D. in 1970, Dr. Harris completed a two-year National Institute of Mental Health Postdoctoral Fellowship at Illinois State Psychiatric Institute. In 1972, he relocated to West Virginia to become an assistant professor in the Department of Biochemistry at WVU in Morgantown, where he has now held the post of professor since 1982.

Active on a number of committees at WVU, Dr. Harris has been honored twice with an Outstanding Teacher Award. A noted author and speaker, he has published or presented nearly 35 articles and abstracts.

Dr. Ledet is a native of Louisana who graduated summa cum laude from Louisana State University School of Medicine in 1968. He did his internship at Confederate Memorial Medical Center in Shreveport, where he was elected the Outstanding Intern and later served as chief surgery resident and chief administrative staff resident.

After his residency, Dr. Ledet served for two years as a staff surgeon at the U.S. Navy Hospital in Lemorre, Calif. For the past 20 years, he has been in private practice in Sulphur, La., where is also a staff surgeon at West Calcasieu Cameron Hospital.

A member of the American Academy of Pain Management and the Society of Laparoendoscopic Surgeons, Dr. Ledet is also active in the Calcasieu Parish and Louisana State Medical Societies. His paper on *"Ambulatory Cholecystectomy Without Disability,"* appeared in the *Archives of Surgery* in November 1990.

Dr. Marshall was born in Ballymena, Northern Ireland. He graduated with honors from the Queen's University in Belfast in 1948, where he received bachelor degrees in medicine, surgery and obstetrics.

After an internship, Dr. Marshall served for three years as an instructor in the Departments of Physiology and Anatomical Pathology at Queen's, where he also completed residency and fellowship training in internal medicine and cardiology, and earned his doctorate of medicine degree. In 1957, Dr. Marshall became a research fellow at the Baker Institute and Melbourne University in Australia, where he published some of the earliest studies about vascular reactivity in hypertension and the antihypertensive and diuretic actions of chlorothiazide.

After his fellowship, Dr. Marshall was awarded a Fulbright Fellowship and spent three years at the Mayo Clinic as an assistant professor in the Section of Physiology and Biophysics. In 1961, he moved to West Virginia to become one of the founding faculty of the WVU School of Medicine, serving as professor and chairman of the Division of Cardiology and as a professor of physiology. During his 15 years at WVU, Dr. Marshall took a one-year sabbatical to be a visiting professor at Oxford.

In 1976, Dr. Marshall moved to Huntington to join the Internal Medicine Group, and he helped to develop the initial facilities at St. Mary's Hospital for cardiac catheterization and open heart surgery. He currently serves as a clinical professor of medicine for both Marshall University and WVU.

A fellow of both the Royal College of Physicians in London and the Royal College of Physicians of Ireland, Dr. Marshall just completed a four-year appointment as governor of the West Virginia Region of the ACP. During his tenure, the West Virginia Region won the Evergreen Award twice.

During his career, Dr. Marshall has served as governor for the West Virginia Chapter of the American College of Cardiology, as president of the West Virginia Heart Association, as vice-president of the American Heart Association, as an advisor for the Royal College of Physicians of Ireland, and as chairman of the Cardiovascular Study Section at the NIH. He is the co-author of three textbooks and over 80 articles.

Dr. Point received his M.D. degree from Harvard University in 1945. He completed his internship and had started his residency at Boston City Hospital when he joined the Army and earned the rank of captain.

After his military service, Dr. Point completed his residency at Boston City Hospital. He then became a clinical and research fellow in gastoenterology at Massachusetts General Hospital, where he also practiced internal medicine and gastroenterology. In addition, he was on the faculty at Harvard and MIT during these years.

In 1977, Dr. Point returned to his hometown of Charleston to practice internal medicine and gastroenterology. He began teaching at the WVU School of Medicine, Charleston Division, where he is now a professor emeritus after serving as a professor of medicine for 13 years. During his career at WVU, he received honors as Teacher of the Year twice and was named Clinician of the Year in 1987.

Dr. Point is a master and former governor of the ACP. He currently serves on the WVSMA's Medical Education Committee, and is on the boards of trustees for the CAMC Foundation, the University of Charleston and Charleston National Bank.

Dr. Brown received his M.D. degree from the WVU School of Medicine in 1972. After interning at Charleston Area Medical Center, Dr. Brown completed a residency in internal medicine in 1975 and a fellowship in cardiology in 1977 at WVU, and he is board certified in both of these specialties.

Since 1977, Dr. Brown has practiced cardiology at Huntington Internal Medicine Group. In addition, since 1982, he has served as director of Cardiology Laboratories at St. Mary's Hospital, where he has served terms as chief of the Sections of Medicine and Cardiology.

A past president of the West Virginia Heart Association, Dr. Brown is a member of Alpha Omega Alpha.

Dr. Layne received his M.D. degree in 1980 from WVU, where he also did residency training until 1983. He later did further postgraduate studies as a faculty development fellow in general internal medicine at UNC at Chapel Hill.

During his career, Dr. Layne has risen through the academic ranks at WVU, where he is now a professor of medicine and associate director for clinical services at the Center for Aging. He is board certified in internal medicine and geriatrics, and has been honored as best attending physician by the WVU Department of Medicine, and by election to Alpha Omega Alpha.

A fellow of the ACP, Dr. Layne has published in the fields of internal medicine, medical education and dietary counseling. He is the principal investigator for several federally-funded research grants.

Dr. Pfister received his M.D. degree from George Washington University in 1962. He interned at North Carolina Baptist Hospital, completed a residency at the Charleston Memorial Hospital in 1968, and then a fellowship in infectious diseases at the University of Colorado.

Since his fellowship, Dr. Pfister has been practicing internal medicine in Charleston, and he is also a clinical professor of medicine at the Charleston Division of WVU. Dr. Pfister has received many honors during his career, including the Laureate Award from the WV Chapter of the ACP, and being named the Clinician of the Year at CAMC. He is a former president of the West Virginia Society of Internal Medicine and the West Virginia Kidney Foundation.

Plan now to attend Lunch & Learn!!!

"Anatomy of Domestic Violence" is the title of the Lunch & Learn program which will take place on Saturday, January 20 at noon during the WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences in Charleston at the Charleston House Holiday Inn in Charleston.

The speaker for this event is Devika Malhotra, a professor of sociology at WVU at Parkersburg. Joining her for a panel discussion will be Barbara Baxter, the assistant attorney general assigned to the Bureau for Social Services of the DHHR, who is chairperson of the Board of Governors of the West Virginia State Bar; Debbie Sizemore of the Family Refuge Center in Lewisburg; and Mark King with the Bureau of Public Health's Office of Emergency Medical Services. CME for physicians and CEU credits for RNs and LPNs will be offered by CAMC.

To register, fill out the Mid-Winter registration form on page 40, or phone the WVSMA at (304) 925-0342.

Happy Anniversary

Still devoted after all these years, Dr. Joe Jarrett and his wife, Astri, of Oak Hill, celebrated their 55th wedding anniversary on December 28. Dr. Jarrett is a member of the WVSMA's Publication Committee and Mrs. Jarrett was named the WVSMA Alliance's Member of the Year for 1995. This picture was taken at the home of Alliance member Donna Glass during the Alliance's Fall Board meeting.

"Dr. Bofill and His Laser Karaoke Show"

Join us for a night
of funfilled entertainment

Trophies!

Dance Contests...

Saturday, January 20
7 p.m.

Charleston House - Holiday Inn
Charleston, West Virginia

Hosted by Acordia of West Virginia and Medical Assurance of West Virginia

Numerous dance contests for those who enjoy the rumba, cha cha, jitterbug and more!

The West Virginia State Medical Association's

1996 Mid-Winter Seminars and Scientific Conferences

January 19-21, 1996
Charleston House - Holiday Inn

Join us for:

- Moving Points in Medicine
- Physician/Public Session
- Live MDTV Demonstration
- Lunch & Learn - The Anatomy of Domestic Violence
- Controversies in Medicine
- Potpourri of Topics
- Entertainment

Appropriate educational credits will be available for physicians and nurses.

Sign Up NOW!

Name _____

Address _____

City _____ State _____ Zip Code _____

County _____ Specialty _____

Phone _____ Fax _____

Payment by: ___ Check ___ Visa ___ MasterCard

Credit Card Payment

Card Number _____

Expiration Date _____

Signature _____

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

Conference Cost:	WVSMA member	$125	_____
	non-member	$175	_____
	nurse	$75	_____
Lunch & Learn	**(Saturday, Jan. 20)**		
	physician	$50	_____
	all others	$35	_____
	TOTAL		_____

The Anatomy of Domestic Violence

Lunch & Learn
Saturday, January 20, 1996
Charleston House - Holiday Inn
Noon to 1:30 p.m.

Whether you are a physician, nurse or work as a member of the medical office staff, you each have a strategic role in identifying possible victims of domestic violence. Learn the telltale signs of domestic abuse and what to do. This session will focus on the underlying causes of domestic violence and the role of the healer in preventing and dealing with the problem on an individual and societal level.

The keynote speaker and facilitator, Devika Malhotra, is a sociology professor at West Virginia University - Parkersburg. A panel of distinguished guests including Debbie Sizemore of the Family Refuge Center in Lewisburg, Mark King with the Bureau of Public Health's Office of Emergency Medical Services and Barbara Baxter, the chairperson for the Board of Governors of the West Virginia State Bar, will participate in this discussion.

The cost is $50 for physicians and $35 for all others. To register, please fill out the registration form on the facing page and fax to Misty at (304) 925-0345.

Appropriate educational credits will be available for physicians and nurses.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs for physicians which will be held in the state and region. Unless otherwise noted, these events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization printed in the *Journal*, contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

January 18
(Teleconference) "New Classifications of Pap Smears and Indications for Follow-Up and Intervention," David W. Anderson, M.D., and Donald H. Chamberlain, M.D.

February 1
(Teleconference) "Violence in the Emergency Department," James P. Griffith, M.D.; Marie E. Renzie, R.N.; and Dawn L. Bacchus, R.N.

February 3-4
"Pacemakers and Devices in 1996: The Non-NASPE Cardiologist Confronts Runaway Technology," Mountain Lodge Conference Center, Snowshoe

February 5-7
"Cardiovascular Conference at Snowshoe," Mountain Lodge Conference Center, Snowshoe

February 15
(Teleconference) "Case Studies in Fetal Monitoring," E. Reed Heywood, M.D., and Elizabeth Rice, R.N.

February 16
"Marketing Strategies for the 90s," 8:30 a.m., Robert C. Byrd HSC Auditorium, Charleston

March 7
(Teleconference) "Enzymes of Myocardial Infarction Ischemia - New Concepts," William H. Carter, M.D.

March 7-8
"Advanced Trauma Life Support Course," Charleston Area Medical Center

March 21
(Teleconference) "Diagnostic Angioplasty," Joseph Skeens, M.D.

Huntington Medical Community Foundation - Huntington

January 18
"Cleft Lip/Cleft Palate," William M. Cocke Jr., M.D., Pleasant Valley Hospital, Point Pleasant, noon

January 23
"Management of Depression Related to Chronic Pain," Kenneth Devlin, M.A., South Williamson Appalachian Regional Hospital, South Williamson, Ky., 5:30 p.m.

February 1
"Diverticulitus from a Surgeon's Perspective," David S. Ratliff, M.D., Putnam General Hospital, Hurricane, noon

February 12
"TBA," Three Rivers Medical Center, Louisa, Ky., 6 p.m.

February 13
"TBA," Lawrence County Medical Center, Ironton, Ohio, 6 p.m.

February 20
"Signs and Symptoms of Abuse for Health Care Providers," Logan General Hospital, Logan, noon

February 27
"TBA," Paul B. Hall Regional Medical Center, Paintsville, Ky., 6 p.m.

Marshall University School of Medicine - Huntington

January 31
"Ob/Gyn Grand Rounds: Fibroid Tumors," Steve McCarus, M.D., 7 a.m., Cabell Huntington Hospital

March 4-5
"9th Annual Research Day," MU Student Center on March 4 at 7 p.m., and Holiday Inn Gateway on March 5 from 8 a.m. - 5 p.m.

March 20
"Ob/Gyn Grand Rounds: Androgens and Women's Health," Ramona Sluplik, M.D., Cabell Huntington Hospital, 7 a.m.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

January 19
"Resolving Conflict in Patient Care" (sponsored by the WVU Center for Health Ethics and Law and the WV Network of Ethics Committees), Robert C. Byrd HSC, Charleston

March 4
"AIDS Teleconference" (sponsored by WV CONSULT and the WVU Office of CME)

March 15-16
"Urology Update 1996: Urinary Tract Stones and Infection" (sponsored by the WVU Depart. of Urology and the WV Urological Society)

WV Chapter of the American Academy of Pediatrics

March 15-16
"Annual Meeting of the WV Chapter of the American Academy of Pediatrics," Parkersburg

West Virginia State Medical Association - Charleston

January 19-21
"WVSMA's 1996 Mid-Winter Seminars and Scientific Conferences," Charleston House Holiday Inn, Charleston

Outreach Programs

Montgomery ☐ Montgomery General Hospital, Jan. 10, 6:30 p.m., "Breast Cancer Prevention and Follow-Up," Steven Jubelirer, M.D.

Parkersburg ☐ Camden-Clark Hospital, Jan. 31, 7:30 a.m., "Violence and Medical Practice: The Many Facets of Domestic, Child and Elder Abuse," Mary Ann Sens, M.D.

★ Camden-Clark Memorial Hospital, Jan. 10, 7:30 a.m., "Post Herpetic Neuralgia," Roberto Valenzuela, M.D.

★ Camden-Clark Memorial Hospital, Feb. 14, 7:30 a.m., "Alzheimer's Disease," Robert Keefover, M.D.

★ Camden-Clark Memorial Hospital, March 8, 10:15 a.m. and 3:15 p.m., "Complications of Diabetes," Rebecca Schmidt, D.O.

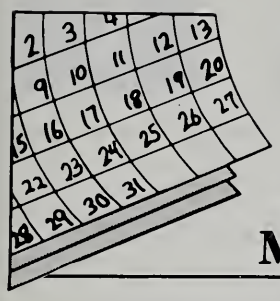
Philippi ★ Broaddus Hospital, Feb. 8, 1 p.m., "Update on Adult Immunizations," R. Wesley Farr, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, January 25, noon, "Update on Colon Cancer," Steven J. Jubelirer, M.D.

Spencer ☐ Roane General Hospital, Jan. 16, 6:30 p.m., "Case Management," Elizabeth L. Spangler, M.D., and Jimmie L. Mangus, M.D.

★ *Robert C. Byrd HSC of WVU*

☐ *Charleston Area Medical Center*



Medical Meetings

January

19-21–The WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences, Charleston

19-21–21st Gastrointestinal Surgery Symposium (sponsored by the American Society of Abdominal Surgeons), Tampa

February

1-4–6th International Prostate Cancer Update, Beaver Creek, Colo.

3-8–Rocky Mountain Conference on Emergency Medicine, Breckenridge, Colo.

4-7–Southeastern Surgical Congress, Tampa, Fla.

5-7–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

6-10–Winter Symposium on Latest Advances in Facial Plastic Surgery (sponsored by the American Academy of Facial Plastic and Reconstructive Surgery), Snowmass, Colo.

8-10–4th Genitourinary Conference (sponsored by the University of Texas and the M.D. Anderson Cancer Center), Houston

10-13–51st Annual Postgraduate Ob/Gyn Assembly (sponsored by the Ob/Gyn Assembly of Southern California), Beverly Hills, Calif.

10-15–American Academy of Dermatology, Washington, D.C.

14-19–12th Annual Conference of the American Academy of Pain Medicine & Review Course & Certification Examination in Pain Medicine, Lake Buena Vista, Fla.

16-18–Comprehensive HIV Management Update for the Primary Care Practitioner (sponsored by the Center for Bio-Medical Communication), New York City

18-20–Cardiopulmonary Rehabilitation: Status '96 (sponsored by the Center for Exercise Science at the University of Florida), Orlando

22-27–American Academy of Orthopaedic Surgeons, Atlanta

March

2-3–Violence: Implications for Clinical Practice (sponsored by the American Psychiatric Association), New Orleans

2-8–Neuro & Ortho MRI Workshop (sponsored by MRI Education Foundation, Inc.), Sydney, Australia

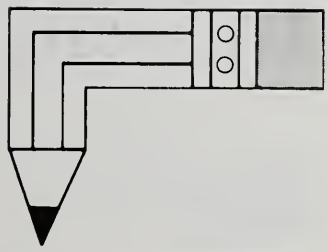
13-16–8th International Conference on the Adjuvant Therapy of Cancer, Scottsdale, Ariz.

15-16–WVU/WV Urological Society Annual Update, Morgantown

15-20–American Academy of Allergy, Asthma and Immunology, New Orleans

For More Information...
Contact the Journal at (304) 925-0342

Poetry Corner



Thoughts For The New Year

Every child on earth is holy,
Every crib is a manger lowly,
Every home is a stable dim,
Every kind word is a hymn,
Every star is God's own gem,
And every town is Bethlehem,
For Christ is born and born again,
When His love lives in hearts of men.

Ralph H. Boone, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

"WHY YES BILLY, I GUESS 'TOWER OF BABEL' COULD BE A REFERENCE TO CONGRESS..."

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

New health commissioner named

Governor Gaston Caperton has appointed Henry G. Taylor, M.D., as the new commissioner for the Bureau for Public Health, effective January 15. Dr. Taylor replaces William T. Wallace Jr., M.D., M.P.H., who announced his plans to retire last summer. Dr. Wallace will serve as a special assistant to the new commissioner during a six-month transition period.

Dr. Taylor brings to his post 13 years of experience in helping people in rural West Virginia communities to identify and address their own health issues. As founder, medical and laboratory director, and teacher at Pendleton Community Care, Inc. in Franklin, he has worked to integrate and expand community-based public health and primary care services.

A graduate of Harvard Medical School, Dr. Taylor holds a diploma with the American Board of Internal Medicine. He is currently enrolled in the Master of Public Health Program at the Johns Hopkins University School of Hygiene and Public Health. His master's studies focus on using innovative community-based health care and field-based health sciences education programs from around the state as model projects for communities throughout West Virginia.

Dr. Taylor says he has found many examples of creative solutions to the health challenges facing the state. "We are leading the nation in developing innovative community interventions, providing practical health solutions and field-based training for public health and other health professions."

Focus given on injury prevention

Injuries take the lives of more than 1,300 West Virginians every year, with the injury death rate in the state 35% greater than the national average. Motor vehicle crashes are the leading cause of injury-related death in the state, followed by suicide, homocide, and falls.

To help reduce death and disability from injuries, the West Virginia Bureau for Public Health's Office of Emergency Medical Services is implementing a new injury prevention program. Program staff will work in conjunction with other members of the West Virginia Injury Control Network to identify the most threatening injuries and populations at risk for them, promote awareness of the effects of injuries, and motivate policy and behavior changes that reduce the toll of injury deaths and disabilities in the state.

The Bureau has recently hired an injury prevention coordinator to oversee the new program activities. Penny Byrnside, R.N., B.A., will be developing a statewide injury plan, and working with numerous state and local agencies and organizations to increase injury prevention awareness and activities. Among the areas to be addressed are seatbelt safety, ATV safety, water safety, hunter safety, firearms safety, and bicycle safety. She will also be coordinating the activities of the Injury Control Network, the West Virginia SAFE KIDS Coalition, and the state's Hospital Trauma Registry which was recently reinstated to collect data about all trauma cases admitted to West Virginia hospitals.

Byrnside was previously the emergency coordinator and inservice educator at Boone Memorial Hospital. She is an emergency medical technician, an instructor in Advance Cardiac Life Support and Basic Trauma Life Support, and an American Hospital Association affiliate faculty member in Basic Cardiac Life Support.

For more information on injury prevention activities in West Virginia, call Byrnside at (304) 558-3956.

More counties adopt clean air rules

As of the first of the year, nearly 47% of all West Virginians will be protected from the hazards of secondhand smoke. The boards of health in Braxton, Lincoln and Upshur counties have become the most recent to pass clean indoor air regulations that designate smoking and non-smoking areas within public places, restaurants and worksites throughout the county.

This brings to 20 the number of counties adopting clean indoor air regulations. Seventeen other counties have previously adopted similiar policies. These counties include Cabell, Calhoun, Clay, Grant, Hampshire, Kanawha, Marion, Mercer, Monongalia, Pendleton, Pleasants, Raleigh, Randolph, Ritchie, Roane, Wirt and Wood.

After a clean indoor air regulation is passed by a board of health, a waiting period is usually required before the policy is implemented countywide. This allows time for businesses and organizations to take the necessary steps to meet the requirements of the policy, which vary from county to county. Of the most recently passed regulations, Braxton County's went into effect October 1, while Lincoln County's became effective January 1 and Upshur County's went into effect on January 4.

Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe or cigar, and the smoke exhaled from the lungs of smokers. This mixture of over 4,000 substances contains more than 40 carcinogens known to cause cancer in humans. The U.S. Environmental Protection Agency (EPA) estimates that secondhand smoke, or passive smoking, is responsible for 3,000 lung cancer deaths in nonsmokers nationwide each year. Additionally, the EPA attributes the effects of secondhand smoke to between 150,000 and 300,000 lower respiratory tract infections in children under 18 months of age every year.

For information on specific clean indoor air regulations, call the appropriate local health department, and for information on passing clean indoor air policies, call the Bureau's Tobacco Control Program at (304) 558-0644.

Coalition for a Tobacco-Free West Virginia
West Virginia Youth Tobacco Prevention Campaign
West Virginia Bureau for Public Health's Tobacco Control Program
and
Charleston Area Medical Center

present

Tobacco Use Prevention and Healthcare: You Can Make the Difference

Saturday, March 2, 1996
8:00 a.m. - 2:30 p.m.
Charleston House Holiday Inn, Charleston, West Virginia

with speakers:
***Tom Houston*, MD - American Medical Association, Director, Smokeless States**
***Elbert D. Glover*, Ph.D. - Tobacco Research Center/Mary Babb Randolph Cancer Center**
***Luke Burchard*, MD - DOC (Doctors Ought to Care)**
Moderator: Michael Lewis, MD, Associate VP for Health Sciences, CAMC/WVU

presented in conjunction with the

Fourth Annual West Virginia Tobacco Control Conference

The Tide Is Turning!

February 29 - March 2, 1996

Registration Form

Tobacco Use Prevention and Healthcare: You Can Make the Difference
March 2, 1996 - 8:00 a.m. - 2:30 p.m.
Charleston House Holiday Inn, Charleston, WV

Name _____ Title _____
Please include ACHE credentials, if applicable

Hospital/Organization _____

Address _____

City/State/Zip _____

The Charleston Area Medical Center's CME program is an approved provider of continuing medical education through the West Virginia State Medical Association. CAMC designates this continuing education activity for four (4) hours of Category 1 credits of the Physician's Recognition Award of the American Medical Association.

Registration fee for this session: $100.00 (includes meals and CME credits). Return with remittance, payable to West Virginia Youth Tobacco Prevention Campaign, to Lisa Lee-Ranson, Program Coordinator, West Virginia Youth Tobacco Prevention Campaign, 100 Association Drive, Charleston, West Virginia 25311.
Phone: 304/344-9744 Fax: 304/344-9745

ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

WVU to offer excimer laser for eye surgery

Macsai

The computer industry developed the excimer laser to etch complex patterns in tiny silicon chips. Now, the laser — which can cut a path as small as a quarter of a micron — is available for use in eye surgery.

In October, the FDA approved a laser surgery called photorefractive keratectomy (PRK) to correct nearsightedness with an excimer laser, and ophthalmologist Dr. Marian Macsai, director of cornea, external disease, and refractive surgery at WVU, served on this FDA panel. Now, University Eye Center has the only excimer laser in the state and Dr. Macsai is already certified in the procedure, which will soon be available to patients at WVU.

This surgery has been in use in other countries for several years and it allows many nearsighted people to discontinue the use of eyeglasses or contact lenses. In other cases, patients who now wear glasses all day will need them only for reading or driving.

According to Dr. Macsa, PRK is a major advance over radial keratotomy (RK), previously the most common surgery for treating nearsightedness.

"With RK, the surgeon uses a diamond knife to cut the cornea. The cutting can cause some weakness, which would be a problem if you are ever struck in the eye. PRK doesn't cause weakness and produces excellent results."

Some ophthalmologists have expressed concern to the FDA and the media that the laser equipment's manufacturer is understating the risks of the surgery and planning to market the procedure directly to patients, bypassing their personal physicians.

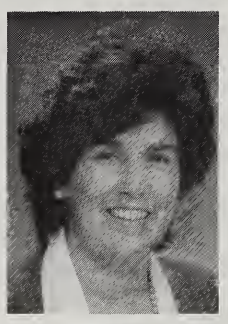
Dr. Macsai said the FDA panel took the objections seriously, but evidence of the benefits of the procedure were strong. She advises people to check with their eye doctor to see if they are eligible for the procedure.

Dr. Macsai has been using the excimer laser since September with another technique, phototherapeutic keratectomy (PTK), to treat patients whose corneas are damaged by scarring or disease.

"Because it vaporizes abnormal tissue without scarring or weakening the cornea, the excimer allows us not just to treat but to eradicate disease without leaving scar tissue behind. In some cases it can take the place of corneal transplant surgery," she says.

For more details, contact University Eye Center at (304) 293-3757.

Rosas creates child advocacy program


Rosas

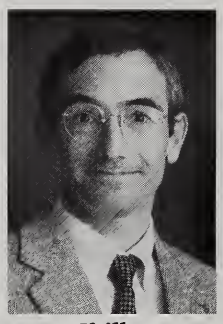
Dr. Angela J. Rosas of the Department of Pediatrics has been awarded a $92,500 grant by the Claude Worthington Benedum Foundation of Pittsburgh to develop a program to coordinate resources for abuse and neglect victims in West Virginia and southwestern Pennsylvania.

Dr. Rosas, who is a specialist in the care of maltreated children, is often called to the Emergency Department to care for injured children, and regularly testifies in court on their behalf.

"Several disciplines serve children who may have been abused or neglected," says Dr. Rosas. "Health care providers, attorneys, psychologists, child protection workers, teachers, and child care professionals all offer resources to abused children. But, often those working for these children are not aware of all of the other resources available."

According to Dr. Rosas, prevention will be the priority for the program since children at risk can be identified.

Chillag named Point Chair of Internal Med


Chillag

Dr. Shawn A. Chillag, professor and chair of the Department of Medicine at WVU's Charleston Division, has been named the Warren Point Chair of Internal Medicine.

A $1 million pledge by the Sarah and Pauline Maier Foundation, Inc., in 1989 endowed the faculty chair position, the first of its kind at the Charleston Division. The position was established to support excellence in clinical research.

The chair is named for Warren Point, M.D., professor emeritus of medicine at WVU. Dr. Point retired in 1988 as director of the Department of Medicine at the Charleston Division and CAMC, but remains active in medical education.

Dr. Chillag, who has been affiliated with WVU since 1978, is assistant dean for curriculum and student affairs at the Charleston Division.

MDTV now at 10 sites

WVU's pioneering two-way audio and video network, Mountaineer Doctor Television (MDTV), now reaches seven community hospitals, one primary care clinic, and two VA medical centers.

Each unit can communicate with WVU physicians in Morgantown and Charleston, and at Sharpe Hospital in Weston. At a demonstration of the system in Martinsburg Dec. 7, VAMC Chief of Staff Dr. Frank Citro invited the Eastern Panhandle medical community to take advantage of the new link for continuing education and for consultations with WVU physicians.

Along with the medical library at the VA, the MDTV link makes the Martinsburg center a key site for physicians in the area to keep up on developments in medicine. In 1996, WVU will offer some 1,200 hours of educational programming over MDTV.

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Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

State's first Rural Health Clinical Fair conducted at Marshall

About 50 medical students turned out on November 9 for a Rural Health Clinical Fair at Marshall, the first event of its kind in West Virginia.

At the fair, preclinical students met with representatives of health teaching sites in the state to learn about requirements and opportunities in rural settings. Also featured at the fair were presentations by fourth-year students and exhibits from sites participating in the state's Rural Health Education Partnerships.

"Our success as a medical school is tied directly to our success with primary care and rural medicine, and it is a success to which we point with pride," Dr. Patrick I. Brown stated.

MU requires its medical students to spend at least four months in rural settings prior to graduation, and many students choose to spend longer. Besides the one- to four-month rotations through the statewide Rural Health Education Partnerships program, Marshall offers students the option of six-month extended placements in rural sites or a track that bases them at a primary care center for the full third year. This year Marshall has students placed at rural sites in 30 West Virginia counties.

"The rural experience gives students a new understanding of medicine at the human level, and they always carry that with them," Dr. Brown said. "It also lets students learn firsthand that so much of primary care medicine can be practiced quite effectively with the technology available in smaller communities."

Rural sites participating at the fair included the Maternal and Child Health Consortium; Grafton City Hospital; Martinsburg City Hospital; Braxton County Hospital; Roane County Family Health Care; the Country Roads Consortium; Boone Memorial Hospital; St. Joseph's Hospital; the Little Kanawha Area Consortium; Pleasant Valley Hospital; and Jackson General Hospital.

Marshall University students learn about educational opportunities from Kim Smith who represented Mountain Health Partners at the Rural Health Clinical Fair.

MU rated 5th in U.S. in number of FP grads entering primary care

According to new data from the Association of American Medical Colleges, Marshall ranks 5th in the U.S. in the percentage of graduates entering primary care specialties.

Released in December, the 1995 Institutional Goals Ranking Report indicates that 40% of Marshall grads between 1989 and 1991 entered primary care practice.

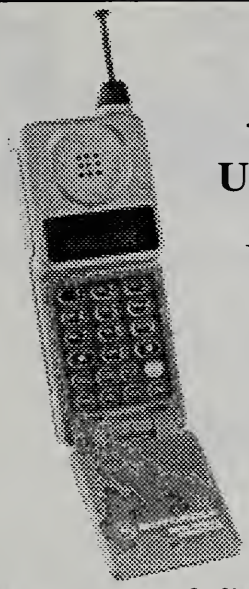
Grads were included if they finished a residency in a primary care specialty and did not participate in a subspecialty or non-generalist program through the 1994-95 academic year. The AAMC used historical stats to estimate the number of grads who are likely to seek subspecialty training in the future.

Plans set for MU's 9th Annual Research Day at Holiday Inn Gateway

Marshall's Ninth Annual Research Day will take place at the Holiday Inn Gateway Convention Center near Barboursville on March 5.

Dr. Stuart F. Schlossman of Harvard Medical School and the Dana-Farber Cancer Institute is the keynote speaker. His lecture is entitled "*What's in a Name - - History of the CD Nomenclature.*" Dr. Schlossman will also speak present the Research Day Opening Lecture on March 4 at 7 p.m. in the MU Student Center. His topic will be *"Human T Cell Activation, CD 26 and CD 27 Mediate Novel Costimulatory Signals."*

For registration information, phone MU's CME office at (304) 696-7019.



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Alliance News

"Join Us . . . It's Catching"

It is time for each member of the West Virginia State Medical Association Alliance to become an ambassador for membership in our Alliance. I am asking each member to make a one-on-one contact with potential members in your county and urge them to join the Alliance. Share with prospective members what you have gained from Alliance membership. It could be self-improvement through leadership training or the experience of being an advocate for the concerns of your physician spouse in the legislative arena.

Ask people who can't or won't be active to support the Alliance with their dues. You could explain how much the WVSMAA means to people, what you do to make people's lives better and how their dues will help to make these vital programs continue.

The WVSMA Alliance offers what no other organization can . . . a unique forum for sharing concerns and a source of support for the medical families of West Virginia.

Since it is so vital that the Alliance continue increasing its membership, monetary rewards will be given to the counties which increase their memberships by the greatest percentage. These awards will be presented in the following categories at the WVSMAA's Annual Meeting: 1st place - $100; 2nd place - $75; and 3rd place - $50.

Kathy Fortunato, WVSMAA vice president, has designed a wonderful t-shirt with our new logo *"Join Us . . . . It's Catching."* For only $6 and membership in the Alliance, you can order one from Kathy by calling (304) 242-2032.

The old cliche that there is strength in numbers is true, but one of the most important outcomes of membership in the WVSMAA will be the lifelong friendships you will develop with other physician spouses. There are many other individuals who share our interests and we need them. Seek and ye shall find!

Amy Ricard
WVSMAA President-Elect

P.S. Remember, the WVSMAA Spring Board Meeting is April 16 at the WVSMA office in Charleston. The Executive Committee will meet at 10 a.m. and the Board of Directors will convene at 11 a.m. All WVSMAA officers and committee chairs, county presidents and president-elects should attend, and we encourage all other Alliance members to participate. Make plans now to join us!

Med Student Section

WVSMA-MSS Annual Meeting

January 20, 1996
Charleston House - Holiday Inn
Charleston, WV

8 a.m. - 8:30 a.m.	**Registration** - Cobb Room
8:30 a.m. - 9 a.m.	**Welcome** - WVSMA President James D. Helsley, MD, and WVSMA Executive Director George Rider
9 a.m. - 10 a.m.	**Special Session** - Jim Woody, AMA-MSS Governing Council Chairman
10 a.m. - 11 a.m.	**Special Session** - *"Identifying the Victims of Domestic Violence"* Debra J. Sizemore, M.S.W., program coordinator of the Women's Health Advocacy Project
11 a.m. - 11:30 a.m.	**Break** - Exhibit Visitation
11:30 a.m. - 12:30 p.m.	**Luncheon** - Provided by WVSMA-MSS
1 p.m. - 4 p.m.	**Business Meeting**

*Presidential Address
*Component Society Reports
*Election nominations
*Committee Reports

WVSMA-MSS Annual Meeting Registration Form

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Will you attend luncheon? _____ Yes _____ No

Please fax or mail to Donna Webb at WVSMA-MSS, P.O. Box 4106, Charleston, WV 25364
Phone: (800) 257-4747 or 925-0342 Fax: (304) 925-0342

WESPAC Members

We would like to thank the following physicians and Alliance members for their 1996 contributions to WESPAC.

Physicians

A Dollar A Day Club
**Designates more than $365*

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Cabell
Deleno H. Webb III
G. William Lavery
Phillip Stevens
Craig Morgan

Eastern Panhandle
Hans U. Juttner
John A. Draper Jr.

Fayette
Sam Davis

Greenbrier
William & Anne Hooper

Hancock
Charles Capito
Sarjit Singh

Harrison
Craig J. Coonley
Doug McKinney
James Bland
James Bryant
Thomas Chang

Kanawha
Thomas Dickie
Michael Fidler
Shozo Kurusu
Ted Jackson
Mickey Neal

Monongalia
Wade Stoughton
Mary Ann Sens
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Ohio
Robert Weiler
Derrick Latos
Ellen Kitts
Larry Dodd
Richard Terry
*David Bowman

Parkersburg Academy
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Johnny Dy

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Michelle Latos
Donna Niess

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Eastern Panhandle
Barbara Hendricks

Fayette
Astri Jarrett

Harrison
Wha Ja Chang

Medical Students

Robert F. Davis
Darren S. Wright

Component Society News

FAYETTE COUNTY

On December 8, the society's regular meeting and Christmas party were held at the Holiday Inn in Oak Hill. Special guests at this event included WVSMA President Dr. James Helsley and his wife, Vickie; WVSMA Alliance President Linda Elliott; WVSMA Junior Councilor at Large Dr. Robert Pulliam; Albert Michaels, administrator of the Plateau Medical Center, and his wife; and Debbie Hon, a representative for Pfizer Pharmaceuticals.

After an invocation by Dr. Jarrett, dinner was served and Lolita Amjad of the Fayette County Medical Alliance presented gifts to Mrs. Helsley and Mrs. Elliott on behalf of the Alliance. In addition, Mrs. Amjad recognized Astri Jarrett with a bouquet of roses in honor of her long service with the Fayette County Medical Alliance and for being named the WVSMA Alliance's Member of the Year.

Next, Dr. Helsley gave on overview of the activities of the WVSMA, and he urged members to join WESPAC and support the WVSMA in its legislative efforts. Dr. Pulliam then reported on the recent AMA Interim Meeting in Washington, D.C., and he recommended members join the AMA. Following Dr. Pulliam's presentation, Mrs. Elliott outlined the goals and accomplishments of the WVSMAA, and encouraged spouses attending the meeting to become active members of their component chapters.

In other business conducted at the meeting, Dr. Jarrett submitted the report of the Nominating Committee and the following new officers were elected unanimously: President - Joe N. Jarrett, M.D.; Vice President - Oscar P. Gosien, M.D.; Secretary/Treasurer - Enrique Aguilar, M.D.; Delegates - Adin Timbayan, M.D., and Victoria Timbayan, M.D.; Alternate Delegates - Ben Muldong, M.D., Rolando Ramirez, M.D., and Serafino Maducdoc, M.D.; Board of Censors - Fred Akerburg, M.D. (Other members are S.S. Maducdoc, M.D., who has one more year to serve; and Adin Timbayan, M.D., who has two more years to serve).

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Obituary

R. Moore Dodrill, M.D.

Dr. R. Moore Dodrill, 74, of Welch, died March 16 at the home of his sister, Dr. Nancy A. Steller of Charlotte, N.C.

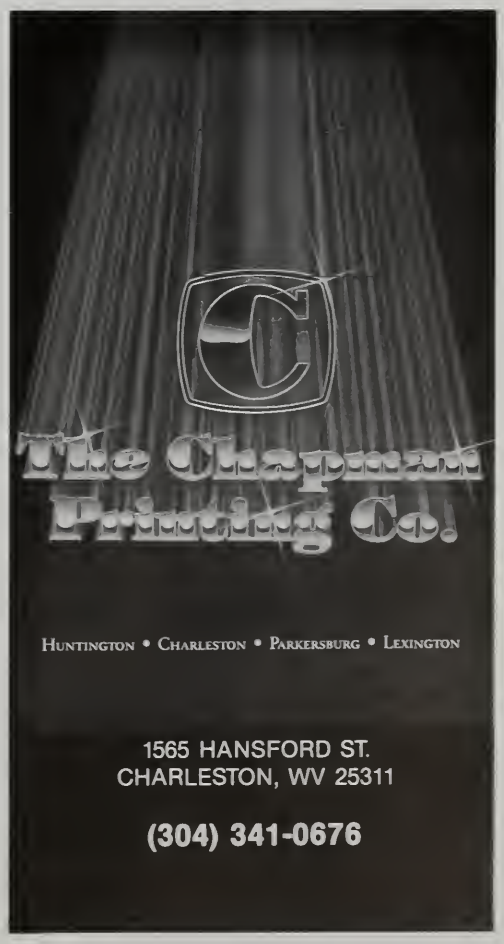
Dr. Dodrill was born in Switchback and he was the son of the late R. Moore Dodrill Sr. and Mae Earle Dodrill. He graduated from West Virginia University in 1943 and received his M.D. degree from the University of Cincinnati in 1944.

After serving in the Army Medical Corps, Dr. Dodrill completed postgraduate training in radiology at the University of Pennsylvania. He practiced radiology in Huntington, Beckley and Williamson for 30 years before retiring in 1982.

In addition to being a member of the WVSMA, Dr. Dodrill was a member of the AMA, the American College of Radiology, and the McDowell County Medical Society. He was a member of Alpha Epsilon Delta Medical Fraternity and the First United Methodist Church of Welch.

Dr. Dodrill's other survivors include one nephew, A. W. Steller of Spartanburg, S.C.; one niece, Mrs. Sally J. McGough of Richmond, Texas; and three greatnieces of Spartanburg.

Memorial contributions may be made to Hospice at Charlotte, 1420 E. 7th St., Charlotte, N.C. 28204.



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West Virginia Health Services, Inc. ..... *Back Cover*

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The Coalition for a Tobacco-Free West Virginia requests your support for its 1996 legislative agenda. This year's legislative goal is to protect youth from using or purchasing tobacco products. Even though it is illegal to sell tobacco products to minors under 18, we are witnessing an alarming rise in teen tobacco use. **The Youth Tobacco Prevention Act** would provide leverage for enforcing the current law by requiring a license to sell tobacco products; require age verification and face-to-face purchases; prohibit vending machine sales of tobacco products, free sampling, and certain promotional efforts. **The Tobacco Excise Tax** proposes an increase on cigarettes to 50 cents per pack, up from the current 17 cents, and a 30% increase on the wholesale price of all other tobacco products, such as smokeless and pipe tobacco and cigars.

For more information about the legislative agenda or proposed bills, contact Michelle Ellison at WVSMA, 304-925-0342, or the Coalition at 304-342-6600.

Coalition for a Tobacco-Free West Virginia

West Virginia Medical JOURNAL

Volume 92 No. 2 West Virginia State Medical Association March / April 1996

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WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published bimonthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on the condition that they are contributed solely to the *West Virginia Medical Journal.*

The views expressed in the *West Virginia Medical Journal* are those of the individual authors and do not necessarily reflect the policies or opinions of the *West Virginia Medical Journal,* its editor, associate editors or staff, or the West Virginia State Medical Association and its staff. Publication of advertisements is not to be deemed an endorsement of any product or service unless otherwise stated.

POSTMASTER: Send address changes to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

USPS 676 740
ISSN 0043 - 3284

Subscription Rates: $45 a year in the U.S.; $80 a year in foreign countries; $4 per single copy. Address communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication and mailing costs, the *West Virginia Medical Journal* will not honor claims for back issues for any reason, unless these claims are received within a 6-month period after issue of the publication requested.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

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West Virginia Medical
JOURNAL

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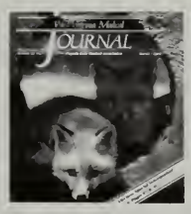
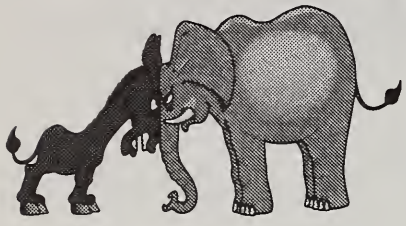


Front Cover

Red fox pups peer out of a hollow log in Upshur County. Photo by *Stephen J. Shaluta Jr.,* West Virginia Department of Commerce.



Gubernatorial candidates answer special WESPAC questionnaire

Editor's Note: The WESPAC Board mailed all of the candidates for governor a questionnaire to obtain their views on issues pertaining to medicine. The following 11 candidates responded.

1. Do you support each of the WVSMA's five tort reform proposals?

A. Collateral Source Rule?

Bob Henry Baber, Ph.D. - Yes. Blame should be shared when applicable.

Larrie Bailey - At first it seems unfair to many people that a plaintiff can suffer an injury, receive insurance compensation, and then perhaps win a court award for the same injury. However, it would also be unfair to reduce the awards of those who have insurance and leave intact the awards of those who do not. In essence, we would be punishing those with enough foresight to insure themselves against injury or loss.

Also, I think that this is a proposal that would benefit insurance companies far more than it would benefit the doctors themselves. Finally, most people, including most people who serve on juries, realize that people usually have some kind of insurance, and they take that into account, informally, when granting an award. Therefore, I cannot support your position on the collateral source rule.

Louis J. Davis - This is a poorly written document. It rambles and lacks clarity. Written surely by a lawyer. The content of the bill does not seem to help or hinder anyone.

Wallace Johnson, M.D. - If justice is truly neutral between plaintiff and defendant, disclosure of collateral sources of payment is essential.

Jim Lees - I believe reasonable reform of the joint and several liability rule is appropriate and possible (to prevent targeting of "deep pockets"). I believe emphasis on collateral source rules are not useful or appropriate.

Joe Manchin III - I support the collateral source rule, on a modified basis, when the court is considering compensatory damages. An injured party should not receive multiple replacements of lost income or other damages since such recovery places the injured party in a better condition than they were in prior to the injury. However, an injured party who has the foresight to insure themselves from unforeseen injuries by buying income disability or credit disability insurance, should be able to recover premiums paid. By allowing the injured party to recover premiums paid, the party that caused the injury will not obtain a benefit because of good planning by the injured party.

I oppose the collateral source rule when the court is considering punitive damages. Since the purpose of punitive damages is to stop future inappropriate actions by a party, the collateral source rule would weaken the public policy purpose of punitive damages. As an example, it is not just to allow life insurance benefits to be used to reduce punitive damages since that dilutes the purpose of the punitive damages.

Jon McBride - Favor.

David McKinley - Support.

Frankie Rocchetti - I will give it the upmost consideration and will get the most qualified people on both sides to work out the best solution so everybody can live with it.

Lyle Sattes - *(Answer to all of Question 1.)* The issue of Medical Malpractice Reform is an example of the type of problem that requires a positive, problem-solving process to reach effective solutions. This process must have people with all points of view come together, seek a common understanding of the problem, look for common ground, select solutions by consensus, work together to implement those solutions and then evaluate to see if the solutions work. It is not an easy process but it is essential if effective and efficient solutions to problems are to be found.

When solutions are developed without everyone having similar understanding of the problem, legislators frequently don't believe the suggested solutions will solve the problem. In many cases, they don't see the problem the same way the proponents of the solution do so they won't support the proposal. That is why in my legislative experience, most legislation proposed from one side or the other fails. When there has not been a process of seeking common ground and consensus solutions, the problem has not been adequately defined in the minds of the legislators.

As governor, I intend to convene and facilitate such a process for the most significant problems facing our society, such as medical malpractice, an issue that must be addressed. This process will focus on problem solving and not fighting and confrontation over the issues addressed. I hope you will agree not only to support such a process, but actively participate in it.

Fred Schell - This could be arbitrary, therefore should be labeled as such 55-7-19. Collateral source (for) evidence (only). The words; (for) and (only) to be inserted as above line.

B. Statute of Limitations?

Bob Henry Baber, Ph.D. - No.

Larrie Bailey - I agree that if someone must sue, they must bring suit as close in time as possible to the accident or event that forms the basis of the lawsuit. Events should be fresh in the minds of doctors and patients, and no doctor should have to fear a suit many years after treatment has been completed. Therefore I support your efforts to reduce the outside limit of the statute of limitations for adults.

However, the language you propose of the statute of limitations for children under the age of 10 would have a very dramatic, and perhaps unintended effect. As I read your proposal, the "whichever comes first" language would limit all children to a two-year statute of limitations period, shorter than that for adults. I could not support such a change. Our children should be entitled to the same outside limit as adults.

Louis J. Davis - This bill appears to be well written and I am in favor of the quoted limit to the statute of limitations. This works against the lawyers of the state and I doubt if it will be passed.

Wallace D. Johnson, M.D. - A two-year statute of limitations, dated from time of alleged injury is fair to all parties and will lower liability premiums, as losses will be more predictable.

Jim Lees - I support reasonable statutes of limiations for adults. I do not support imposing a duty on a child under the age of consent to comport with a statute of limitations.

Joe Manchin III - I am not wholly supportive of the statute of limitations legislation that the WVSMA is advocating. I do agree with the limitation being reduced to six years, but I do not agree to the reduction in that statute for children under 10. While we do need to address the issue of suits being brought years after a medical professional has treated a patient, we also must provide for our children who should be afforded extra protections.

Jon A. McBride - Favor

David McKinley - Support.

Frankie Rocchetti - Same comment as Collateral Source Rule.

Fred L. Schell - For equality under the law, subsection (b) and all mention thereof should be deleted. And, subsection (a) in line #18, should have the word (a) deleted and replaced with (any) i.e. to (any) person.

C. Certificate of Merit?

Bob Henry Baber, Ph.D. - This sounds reasonable, but will it just add another level of red tape? I'd have to study this further.

Larrie Bailey - I support your proposal to require a certificate of merit in malpractice actions. Meritless cases are obviously a problem, not just for doctors, but for all of us in the way they increase the cost of insurance, and health care, for everyone. I would support a change in the West Virginia Rules of Civil Procedure to allow a court to dismiss a suit when the plaintiff has not obtained a doctor's report within a certain time of filing suit.

Louis J. Davis - My God! This is pure legal robbery and a useless piece of legislative work. Definitely written by the lawyers in the Legislature. Patients and medical care providers will be the big losers. I am absolutely in favor of limiting the attorney fees. But, this is like passing a law to enable the poor to run for the office of governor and then set the campaign spending limits at $1 million.

Wallace D. Johnson, M.D. - I favor a malpractice panel, as in Indiana. This consists of two physicians and one lawyer. Findings of the panel are admissible in court. Ninety percent of cases denied by the panel are dropped. Plaintiff never loses the right to sue.

Jim Lees - I do not support certificates of merit to the extent the lack of one would bar the constitutional right to trial by jury. I do support preliminary panel litigation as a pre-requisite to a trial, with the decision of the panel admissible in a subsequent trial.

Joe Manchin III - I strongly support the certificate of merit provisions that the WVSMA advocates. Before we clutter our court calendars with cases there should be at least a minimum level of evidence to establish the veracity of a claim.

Jon A. McBride - Favor.

David McKinley - Support. This is similar to legislation I introduced in 1981 and 1982 (HB 1416 and HB 1456). I anticipated that this would become more of an issue and hoped that we could have avoided reacting to it later.

Frankie Rocchetti - Same comment as A.

Fred L. Schell - I believe fully in liability lawsuits having merit, but this could make health care providers as sole arbitrators, colliding with justice. Attorneys, themselves should be held liable for bringing ludicrous cases to trial, in which case they wouldn't be so greedy.

D. Periodic Payments?

Bob Henry Baber, Ph.D. - Sounds reasonable - What are the arguments against it, I wonder?

Larrie Bailey - I would support this idea if it is applied to doctors who are personally liable to a victorious plaintiff, because it doesn't help anyone to force a doctor into bankruptcy. I also agree that many plaintiffs do not spend their money wisely once they receive it, and that judges should have the discretion to impose some sort of structured settlement, as they now have in cases involving minor children.

I do not think that insurance companies should be the beneficiary of such a rule, and I again question if the intent of this proposed change is to benefit the doctors or their insurers. We must remember that once a plaintiff wins a judgment, that money belongs to the plaintiff. To allow a large company the benefit of investing the award while making only periodic payments is unfair. Protecting the

small practitioner from bankruptcy, however, is fair, and I would support periodic payments in those cases where a doctor's practice is threatened.

Louis J. Davis - Again, this work concerns itself FIRST with the attorneys. Plaintiff and the defendant are considered last. I like the periodic payments and support it, but would want to see the principals of the case considered first.

Wallace D. Johnson, M.D. - Lottery winners get periodic payments. It should also be true for the malpractice lottery. This allows carriers to set reasonable premiums.

Jim Lees - I have no problem with the periodic payment concept so long as 1. such payments are fully guaranteed and secured, and 2. sufficient up-front monies exist to pay costs and expenses.

Joe Manchin III - I do not support the periodic payment provision. While I am aware of the financial implications an adverse judgement can have on a person, I do not support the use of legislative fiat to control and limit the options available to our judges in the settlement of litigation. Such matters should be negotiated by the litigants and not imposed.

Jon A. McBride - Favor.

David McKinley - Support.

Frankie Rocchetti - Same comment as A.

Lyle Sattes - Same comment as 1A.

Fred L. Schell - Subsection (a) should be $200,000 and periodic payments should not be less than $50,000 per year.

E. Sliding Fee Scale for Plaintiff Attorneys?

Bob Henry Baber, Ph.D. - I support this.

Larrie Bailey - As I stated, I support making some change in the way attorneys are compensated in malpractice actions. However, I do not agree with your proposed schedule. The cases that most harm the medical profession are not the rare cases with multimillion dollar awards, but rather the countless, small claims cases of questionable merit. To increase the percentage for lawyers to 40% in actions under $50,000 would actually encourage more "harassment" or "stike suit" cases and have a detrimental effect on the practice of medicine.

I propose lowering the lawyer's percentage to 25%, in medical malpractice cases, which would discourage lawyers from taking those questionable cases that are harming the medical profession. Such a change, combined with an increase in binding arbitration, implementing practice guidelines, and requiring a certificate of merit will dramatically improve the practice environment in West Virginia.

Louis J. Davis - This bill appears to be OK, but to me it does not say very much. Maybe, I need experience in claim filing.

Wallace Johnson, M.D. - If the object of the law is to recompense injury, more must inure to the injured party.

Jim Lees - I do not support legislation that attempts to limit contractual relationships between clients and attorneys, whether such attorneys are plaintiff, defendent or corporate.

Jon A. McBride - Favor.

David McKinley - Oppose. Because of my free-market position and opposition to additional government interference.

Frankie Rocchetti - Same comment as A.

Lyle Sattes - Same comment as A.

Fred L. Schell - Attorneys fees should not be more than 30% up to the first $50,000 and decreased to 25% thereafter up to $500,000, then be reduced to 15% thereafter.

2. Do you support free-market alternatives to health system reform?

Bob Henry Baber, Ph.D. - Yes, to a certain extent. But we must be careful that HMOs and corporations such as Humana don't "cream" the system - taking the healthy and leaving the sick behind.

Larrie Bailey - Yes. I do, if you mean by this question, do I think that competition and the free market are the best tools we have to lower medical and insurance costs while still guaranteeing quality medical care. The government still has a role, however. I believe that the government, and the medical profession itself, have an obligation to ensure that our doctors are well trained and that hospitals, HMOs and insurance companies provide access to health care for all citizens, both urban and rural.

Louis J. Davis - I do support free-market alternatives, but I expect the free market to provide more professional care to more West Virginians at less cost to the people and the state.

Wallace Johnson, M.D. - I favor medical savings accounts for Medicaid, Medicare, public employees and private insurance. I favor provider-sponsored networks being able to contract directly with Medicare and Medicaid with markedly reduced capital requirements.

Jim Lees - Yes. As we move into managed care, the role of HCCRA needs to be converted into a data-gathering agency and not a rate-setting agency. This transistion will entail a consistent move to free-market competition in health care.

Joe Manchin III - I fully support free market solutions to the health care system. As governor I will change the role of HCCRA, I will eliminate its restrictive regulatory powers that discourage reform. Instead it will be an information gethering body, used to help guide free-market choices.

Jon A. McBride - Yes.

David McKinley - Yes.

Frankie Rocchetti - Yes.

Lyle Sattes - Yes.

Fred L. Schell - I support free-market alternatives, but we also need some health care reform, in order to see that no person should be denied needed health care because of inability to pay, and I want to be able to assure West Virginians that we care, and people that fall between the cracks can be treated.

3. Do you support a patient's right to choose his or her own physician?

Bob Henry Baber, Ph.D. - Yes. But I would trade choice for more universal coverage if need be.

Larrie Bailey - Yes. The patient, and not the government or the administrator of an HMO or a hospital, should choose his or her own doctor. However, I think that as long as an HMO provides a broad selection of competent doctors from which to choose, that it is acceptable for the HMO to require a choice from among its own doctors.

Louis J. Davis - Yes. If the patient is mentally competent and if he/she has a choice, i.e., more than one M.D. in that field.

Wallace Johnson, M.D. - Yes. Closed panels are typically chosen from providers granting discounts or willing to cut quality of care.

Jim Lees - Yes. I believe this right is basic and must be preserved within reason. I recognize it may be necessary in managed care to "lock-in" patients to their choice of physician for some time period, but I want as much flexibility as possible in both choosing and changing physicians.

Joe Manchin III - I am committed to protecting every patient's right to choose their own physician. I am also committed to every physician's right to participate in a managed care program. This is particularly true since every physician is responsible to pay the medical provider tax which supports many state-sponsored health care programs. Managed care programs can be designed to allow broad physician participation and patients the right to choose their own physician. A Governor Manchin administration will work to expand the health care options for West Virginians, not limit them.

Jon A. McBride - Yes.

David McKinley - Yes.

Frankie Rocchetti - Yes. Because it is our constitutional right and our soldiers and veterans fought in many wars for us to have a choice and now our freedom is on the line.

Lyle Sattes - Yes. This is possible even in the coming managed care environment.

Fred L. Schell - Yes. Again, I support the free market system, but we must somehow see to it that no person is denied affordable health care, nor should any person be denied health care when needed. Elective health care should be left up to each person's wants and ability to pay.

4. Do you believe we should increase the allowable income for those who receive Medicaid?

Bob Henry Baber, Ph.D. - Yes. I believe health care is a right. In our rich nation all people should be covered. We especially need to make sure children are covered.

Larrie Bailey - No, not at this time. While I agree that we still must tackle the problem of our uninsured citizens, any increase in the number of people eligible for Medicaid would be irresponsible at this time, in light of the current problems our Medicaid program is facing, and the enormous cuts in Medicaid proposed by the federal government. Even with a proposed savings of $157 million from cuts proposed by the Governor's Medicaid Crisis Panel, the state's Secretary of Health and Human Resources has projected a $65 million deficit in the Medicaid program at the end of the fiscal year. Although we do not yet know what will happen in Washington, we are virtually assured a significant decrease in the amount of funding West Virginia receives for the Medicaid program. Therefore we cannot add to the problem by increasing the allowable income for Medicaid recipients.

Louis J. Davis - Yes. I am going to initiate a jobs program in WV called the West Virginia Reconstruction Program. This program will create 77,000 jobs that will offer wages and benefits that will greatly reduce the burden on Medicaid.

Wallace Johnson, M.D. - No. Any move to increase Medicaid rolls should be opposed. Currently 366,000 of the state's 1.78 million residents, or 20% of the population is on Medicaid. This is too big a tail for a small dog to wag.

Jim Lees - No. While I certainly would like to do so, the reality is during the next two years we cannot afford to do so. Therefore, I am constrained to answer no, my best intentions not withstanding.

Joe Manchin III - Medicaid and Medicare are not going to exist as we know them today by the time the next governor is inaugurated. With Washington poised to move these programs to the states in the form of block grants, any policy choices we make today are strictly hypothetical. Still, in all I am committed to continuing the needed medical care provided through these programs and will strive to use the resources available to the next governor to provide quality care to the greatest number of West Virginians.

Jon A. McBride - No. Increasing allowable income would increase the number of Medicaid-eligible persons, and would not be possible at present funding levels. If managed care principles were applied to the Medicaid program, then it might be possible to expand eligibility without exploding the Medicaid budget.

David McKinley - No. Until we can better prioritize the expenditure of funds in Medicaid and in particular the optional programs, it would be counterproductive for us to raise the tax burden further. If representatives of the medical community and our administration opt to transfer funds from optional selections or other aspects of Medicaid to finance this enhancement, we will consider the switch; but not if it means additional taxes.

Frankie Rocchetti - Yes. In most cases their income is to low to meet their needs as is.

Lyle Sattes - Yes. A major part of welfare reform has to allow a person on welfare to improve his or her job and income without immediate loss of health care coverage for themselves and their family.

Fred L. Schell - Yes. There are too many persons that fall between the cracks and costs put them into bad credit circumstances that sometimes destroys their whole lives just because they cannot pay medical bills on time. We need to give people a hand up, not a hand-out, but could allow persons to make payments into a central fund, that I would create and put in place for them to contribute to as they can afford and be open to all other contribution sources.

5. If you answered yes to Question No. 4, how would you suggest we fund such a program?

Bob Henry Baber, Ph.D. - Alas, we have no answer. With impending federal cuts, West Virginia's Medicaid debt will only go higher. Without a national health care plan, we can do little to move forward. I believe in the Canadian system and universal coverage. We should control duplication of expensive diagnostic equipment and facilities, monitor "defensive" tests that are unneeded and grapple with costly "heroic" measures.

Louis J. Davis - A vast amount of taxes will be created by salaries of 77,000 new money spenders in the state. I also intend to tax those attorneys that are reaping all the benefits from these malpractice suits.

Frankie Rocchetti - To cut out the waste of all our programs and the money that can be saved from welfare, lottery, etc.; and from dog and horse tracks.

Lyle Sattes - Such a program could be partially funded by sliding scale premiums as a worker's income rises. Another possible approach could be to combine the purchasing power of state programs, i.e., PEIA, Workers' Compensation and Medicaid, to reduce the cost of the combined expenditure and fund this change.

Fred L. Schell - Perhaps we could fund part of this by the use of the so-called sin tax mentioned in Question 6.

6. Would you support an increase in the state tax on cigarettes?

Bob Henry Baber, Ph.D. - Yes. I support a 50 cents per pack increase, a portion of which would be dedicated to anti-smoking campaigns. I also believe the state should go after the cigarette companies.

Larrie Bailey - Yes. See next question for comments.

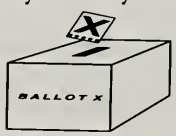
Louis J. Davis - I have always been a non-smoker and been aware of the damage smoking can do to everyone involved or not.

Wallace Johnson, M.D. - Yes. Current tax of 17.5 cents per pack established in 1978, I would quadruple to 70 cents and place a tax on cigars, pipe tobacco and smokeless tobacco which are presently untaxed.

Jim Lees - Yes. So long as all revenue from such increase is designated to health care. I might also add that I place alcohol in this same category.

Joe Manchin III - I am not familiar with the full implications of an increase in the cigarette tax and therefore could not provide an informed opinion at this time.

Jon A. McBride - Yes. I would support a tax increase on cigarettes as a public health matter, but not as a fiscal matter. As a fiscal matter, I support lowering key tax rates as an incentive for increased economic activity. However, I have long been an advocate for healthy lifestyles for youths, and believe that an increase in the cigarette tax would discourage kids -- and some grown-ups -- from smoking.



David McKinley - No. I have pledged in writing to raise NO taxes during my administration. Attractive as "sin taxes" may be, I don't intend to break my commitment.

Frankie Rocchetti - No. If cigarettes are raised that will force every smoker to go out of state to buy the cigarettes.

Lyle Sattes - Yes. The effort to reduce smoking must include positive education about wellness.

Fred L. Schell - Yes. I would support an increase on the use of all tobacco and alcohol user fees (taxes). Then, use one-third of the income for health care, one-third for treatment and one-third for education.

7. If there is an increase in the state cigarette tax, would you support a requirement that all or part of the increased revenue be designated to support health-related programs?

Bob Henry Baber, Ph.D. - Yes.

Larrie Bailey - Yes. I certainly do support taxes on tobacco and alcohol to help fund health care programs. These two products cause an enormous amount of our medical costs, and it only makes sense to tax these products to help offset those costs and to discourage use. A recent article in the *Journal of the American Medical Association*, investigated deaths in the year 1990. Examining the 2.1 million deaths that year, the study analyzed the official causes of the deaths and the actual risk factors that produced the deaths. The study revealed that two agents, tobacco and alcohol, accounted for over 20% of all the deaths that year, over 400,000 people. In addition to the deaths, tobacco use and alcohol use create tremendous costs in treatment, lost work, reduced productivity, and injuries sustained in accidents. If we can reduce consumption and increase available funds by making some increase in the taxes on these products, it would be wrong not to do so.

An important concern, however, is what we do with the extra funds produced by the tax. One area we should concentrate on is education. A recent study found that West Virginia has the highest teen smoking rate in the country. Obviously, we must do more to discourage our teens from smoking, and a statewide educational program aimed at teenagers, funded by an increase in the cigarette tax, could do much to reduce that shameful statistic.

Louis J. Davis - Yes.

Wallace Johnson, M.D. - Yes. The burden must be shifted from those who treat disease to those who cause disease.

Jim Lees - Yes.

Jon McBride - Yes.

David McKinley - Yes.

Frankie Rocchetti - Yes.

Lyle Sattes - Yes.

Fred L. Schell - Yes. All income from a new tax on cigarette, tobacco and alcohol should be used on health related issues at least as much as I have stated in question number 6.

8. Would you support legislation that would strengthen the domestic violence laws in our state?

Bob Henry Baber, Ph.D. - Yes. I am strong on this issue.

Larrie Bailey - Yes. Too often, claims of domestic violence are not taken seriously until it is too late. I support efforts that will require police to investigate fully any claim of domestic violence, and give them authority to actually arrest the abusive spouse or parent on the spot. Also, when a spouse has obtained a protective order, we should prosecute any violation of that order to the fullest extent of the law.

Louis J. Davis - Yes. As a federal agent, I have seen the damage done by domestic violence. I do NOT believe in writing laws just for laws' sake or for some fad. I want to see if the laws we have now are working, whether we need more enforcement or whether we need more education, etc.

Wallace Johnson, M.D. - Yes. Police must be free to act on probable cause. Repeat offenders should do jail time.

Jim Lees - Yes. As a former prosecutor who has prosecuted 44 first-degree murder cases and six death penalty cases, and having been a police officer, I fully support such legislation. I also want to eliminate parole, adopt truth in sentencing and fully fund a statewide state police detective bureau.

Joe Manchin III - Domestic violence is a scourge. I strongly support the immediate strengthening of our laws dealing with domestic violence. So long as we tolerate violence in our homes, we will never end violence in our streets.

Jon A. McBride - Yes.

David McKinley - Yes. As a critical care nurse, my wife is keenly interested in this issue and is prepared to focus her efforts in our administration to make the necessary improvements.

Frankie Rocchetti - Yes.

Lyle Sattes - Yes.

Fred Schell - Yes. I believe that police upon inspecting and finding cause supporting domestic violence, the perpetrator should be removed from the scene and charges filed for battery whether or not victim wants to file. Counseling should be a prerequisite after a 24-hour cooling off period for first-time offenders in lieu of fines.

9. What do you view as the most important problem with the present health care delivery system?

Bob Henry Baber, Ph.D. - The 40 million uninsured people. I am one of them - probably the only candidate in this fix.

Larrie Bailey - Our most important problem is high cost of medical care, and the alarming rate of cost increases. Every year the cost of health care increases at several times the rate of inflation. A short hospital stay could bankrupt a family without insurance coverage, and as costs increase, so do insurance premiums, and so do the ranks of the uninsured.

We must do all that we can to control costs, including simplifying and standardizing paperwork and forms, encouraging the use of HMOs, and providing malpractice reform that will decrease the need for defensive medicine.

Louis J. Davis - Not enough native West Virginian physicians. The care we have is not taken to the people who need it. Those who need care are too often sent out of the state.

Wallace Johnson, M.D. - 1. The provider tax - only three states have one and Kentucky has a new physician lieutenant governor pledging to eliminate it, leaving West Virginia and Minnesota. We should also eliminate this unjust burden. 2. Worker's Comp should be privatized. 3. Elimination of prior "medicaidization" of social services: washing dishes, scrubbing floors, schools for handicapped are not health care.

Jim Lees - Balancing fair and open competition in the market place versus meeting the needs for health care in the rural areas. When you add in the Medicaid problem and the possibility of less federal money, the next governor must be prepared to deal with these issues.

Joe Manchin III - The most important issue in health care delivery is the need to expand adequate coverage to all people. The United States has the greatest health care system in the world but not everyone has real access to it. Questions of portability and preexisting conditions are only on the surface of the larger issues of the uninsured and uninsurable. These people, who are not covered by insurance, are a significant factor. The costs imposed on the system by the uninsured when they do get sick are born by all who are in the form of higher premiums. We must, as a state and a nation, take the deep breath, swallow hard and face this growing issue. If we do not it will consume us.

Jon A. McBride - Access to quality health care, particularly in our more rural areas, remains a problem for many West Virginians. In general, I believe the private marketplace is the best hope in this regard. A strong economy will build our population and can help attract additional practitioners to more rural areas. Government's role should be to ensure an economic and population base which assures accessibility and maintains patient choice. West Virginia today has the best health care in its history, but it is not always available where and when needed. Government policy must secure the advances in the healing arts for all of our people.

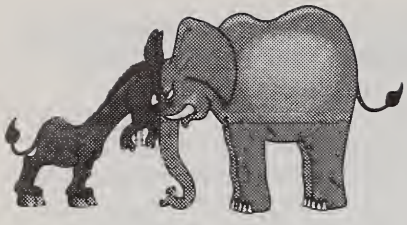
David McKinley - The industry is overly regulated by government, does not respond adequately to the misrepresentations that periodically appear in the media and has failed to articulate in an understandable manner the cost to the public of defensive medicine and government interference.

Frankie Rocchetti - It can be improved and stop these doctors from making false applications claiming they've seen patients that don't exist and to bankrupt our Medicaid/Medicare system.

Lyle Sattes - In Chapter 6 of the *Third Wave and West Virginia*, I discuss health care delivery problems in depth.

Fred L. Schell - Affordability of health care and accessibility are of utmost importance. Then comes the over medication of seniors and other persons suffering pain. Many people take over the counter medications that they should first seek advice from their physicians. Education and exercise should be a factor stressed more by physicians.

See next page & p. 96 for more election information.



Supreme Court candidates offer biographical info, statements

Editor's Note: WESPAC requested Supreme Court candidates submit a biographical sketch along with a statement as to why they should be elected to the high court. The following candidates responded.

JOSEPH P. ALBRIGHT of Parkersburg, graduated with a law degree from the University of Notre Dame. He has been in private law practice from 1962 until September 1995 when he was appointed by Governor Caperton to the West Virginia Supreme Court of Appeals to fill the unexpired term of retired Justice William Brotherton Jr.

Justice Albright served in the West Virginia House of Delegates from 1971-1972 and from 1975-1986. He served as chairman of the House Education Committee, as chairman of the Judiciary Committee and as Speaker of the House.

Statement: I have been privileged to serve in the House of Delegates of the West Virginia Legislature, as an asssistant prosecuting attorney and city attorney, and, over the years, as a member of various governmental boards and commissions. As a past chair of the House Education and Judiciary committees, a former Speaker of the House of Delegates, most recently as a member of the state Ethics Commission and by my other governmental service, I bring to the West Virginia Supreme Court of Appeals extensive experience in and knowledge of governmental affairs and organization which is truly unique among the various candidates for this office. The perspective gained from this service is both highly practical and profoundly respectful of the separate and distinct functions of the three branches of state government and the rights and privileges reserved to the people of our state.

I have practiced law in Parkersburg for over 33 years. That practice was devoted to dealing with the personal and business legal problems of literally hundreds of clients, including professionals, such as physicians, nurses and other health care providers, and small and medium-sized businesses as well as organized and unorganized workers. From that experience, I have gained a wide acquaintance with and practical understanding of the legal problems ordinary citizens, independent professionals and business people encounter in their day-to-day lives.

In addition, prior to my appointment to the Court, I maintained an active role in the conduct of my family's business interests as well as a leadership role in the business side of the conduct of the law partnership of which I was a member. In those roles, I gained a thorough, "hands-on" appreciation of the difficulties one encounters as an employer, in meeting payrolls and benefit costs and in otherwise managing a business.

Finally, as a currently sitting Justice, my election to the Court in 1996 would promote stability on the Court by preventing, or at least limiting, further disruption in the current makeup of the Court, which has had three new appointments to it in a little more than a year.

I respectfully suggest that my experiences and perspective will serve the interests of the people of this state by providing appropriate judicial restraint, careful and fair judgment for all litigants appearing before the Court, a healthy regard for the duties and proper roles of each of the departments of government and a finely-honed respect for the rights and privileges of all citizens.

ARTHUR M. RECHT is currently sitting as a Justice of the West Virginia Supreme Court of Appeals, being appointed by Governor Caperton in 1995 to fill the unexpired term of retired Justice Richard Neely. Prior to that Justice Recht practiced in the law firm of Schrader, Recht, Byrd, Companion & Gurley in Wheeling. He served as a judge for the First Judicial Circuit covering Hancock, Brooke and Ohio counties from 1981-1983.

He received his law degree from the West Virginia College of Law in 1962 as Order of the Coif.

Statement: I accepted my appointment to the West Virginia Supreme Court of Appeals in May 1995 because I felt that my 30 years experience as a trial lawyer, three years as a trial judge, chairman of the State Bar Committee on Legal Ethics, and bank director would provide the experience and perception to best understand and resolve legal disputes presented to the only appellate court of this State.

Now that I have been a sitting Justice for more than nine months, I have heard and decided numerous cases, and I know that I have the scholarship, work ethic and temperament to be the type of Justice that will best serve all of the citizens of West Virginia. That is why I desire to remain on the Court for at least another twelve years.

RICHARD A. (RICHIE) ROBB has been mayor of South Charleston since 1975, elected six consecutive terms. He received a degree in history from Marshall University and a law degree from Capital University.

Statement: I bring to this campaign the perspective of one who has been a client or party in the judicial system (mayor of a municipal corporation for 21 years) as well as that of an attorney. The legal system in this state and nation has increasingly distanced itself from reality and the mainstream of society. This has caused adverse repercussions both within the legal system and with society at large.

It would be my goal to attempt to bridge this gap. As a start, my campaign will NOT be accepting financial contributions from other lawyers. This is a pervasive practice in West Virginia's judicial elections that provides an overwhelming majority of candidates' financial support. If nothing else, parties before the court are, at the very least, entitled to fairness. The practice of attorneys making financial contributions to the very judges before whom they appear creates the appearance, if not the reality, of unfairness.

I support strengthening judicial authority at all levels of our legal system. Unnecessary abuse, particularly by lawyers,

increases costs, limits access to the legal system and hinders the fair administration of justice. Refusing campaign contributions from lawyers would be a first step in curbing this abuse and restoring respect for the system.

DANNY STAGGERS graduated from Harvard University in 1975. He received his law degree from Georgetown University Law School in 1978. He is also a certified public accountant.

Mr. Staggers currently practices at Staggers & Staggers Law Firm in Keyser. He also has been counsel for the State Judicial Hearing Board since 1986. The board recommends disposition of cases involving complaints against Supreme Court justices, circuit judges, law masters and magistrates.

Mr. Staggers served as prosecuting attorney for Mineral County from 1981 until 1985. He served as a hearing examiner for the State Human Rights Commission when the commission's cases were backlogged in 1985. He has taught income tax accounting at Potomac State College and has conducted seminars for magistrates and accountants.

LARRY STARCHER has been a judge on the 17th Circuit Bench for 19 years. During his time on the bench, Judge Starcher has been responsible for general administration of a two-judge, four-magistrate state trial court circuit.

Judge Starcher received his law degree from West Virginia University Law School. He resides in Morgantown.

Statement: Because of my personal background, legal career and judicial experience, I believe that I have a very good chance to be elected. I have been a circuit judge in Monongalia County for over 19 years and assigned to sit as judge by the Supreme Court in 23 of our 55 counties. I am the candidate with the most judicial experience. And, in mid-January I came in a high second in a statewide Ryan McGinn, Inc. poll "running" against the two incumbents.

I became a private lawyer in 1976 and ran for circuit judge, won, and have twice since been re-elected.

As a judge I have enjoyed a reputation of being hardworking, sensitive to family and children matters, tough on criminals by sending all serious offenders to jail or prison and requiring less serious offenders to pay victims damages and to perform community service tasks to repay the community. For example, I have supervised and worked with jail inmates at Pricketts Fort State Park, building a large 1870 log barn for public use.

Last year, as Chief Judge in our county, I designed, supervised, and actually worked on the construction of a new magistrate court and family law master facility. We built it by using mostly county maintenance staff and jail labor. It saved our local taxpayers over $500,000.

I am known as a fiscal conservative who has kept the costs to taxpayers for representation of criminals at a minimum, and to the extent possible, I make convicted criminals pay for the costs of their prosecution. Also, I expedite my docket to keep costs to all litigants at a minimum. Over the past 19 years I have tried thousands of asbestos cases, many complicated medical-related cases and about every type of case imaginable.

As judge I have held all offices in the West Virginia Judicial Association. I have taught at the National Judicial College in Nevada, and also twice yearly I have instructed municipal judge, magistrate and clerk training for the WV Judicial Association. In addition, I have conducted many seminars and taught as an adjunct lecturer at the WVU College of Law.

BOOKER T. STEPHENS of Welch, is currently the Chief Judge of the Eighth Judicial Circuit in McDowell County. He was elected to a second eight-year term on the court in 1993.

Judge Stephens graduated from West Virginia State College in 1966 with a B.A. in political science and Spanish and received his law degree from Howard University School of Law in 1972.

Statement: The most unique qualification that I have for seeking a seat on the Supreme Court of Appeals is experience and more specifically judicial experience. I have been in the private practice of law for 12 years. I have just entered my 12th year as a Circuit Court Judge. I have served as Chief Judge of the Circuit Court of McDowell County for six of those 12 years. Former Chief Justices Brotherton, Workman, Neely, and Miller and current Chief Justice McHugh, have all shown confidence in my judicial abilities by appointing me as a designated member to sit on the Supreme Court of Appeals on eight separate occasions since 1985. My 12 years in the practice of law was my internship. My 12 years as a circuit court judge has served as my residency. I have completed both successfully and am now ready to be a member of the Supreme Court of Appeals. Experience counts and I have spent most of my adult life obtaining the necessary experience for the office of which I seek.

JOHN C. YODER, a resident of Harpers Ferry, was elected to the West Virginia Senate in 1992. He graduated from the University of Kansas Law School in 1975 and completed the M.B.A. program at the University of Chicago the following year with a concentration in finance. After that, he taught business at Goshen College. A constitutional law attorney, he is also a graduate of the National Judicial College.

In 1977, Senator Yoder was elected to a circuit judge position, becoming the youngest person in the United States to hold a position as a state circuit judge. In 1980, Judge Yoder was selected in a national competition to serve as a Judicial Fellow at the U.S. Supreme Court. After one year as a Fellow, he was appointed to a position at the Supreme Court as a special assistant to Chief Justice of the United States, Warren E. Burger.

Yoder was also appointed as the First Director of the Asset Forfeiture Office at the U.S. Department of Justice. In that position, he organized and managed the new Asset Forfeiture Office, to coordinate the Federal efforts to seize illegal profits and property of those involved in drug trafficking. The U.S. Department of Justice gave him an outstanding performance rating in that position for his efforts in establishing the new subdivision.

See page 96 for a special primary election alert from WVSMA President Dr. James Helsley!

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SPECIAL SECTION

Mid-Winter Clinical Conference

Highlights of the West Virginia State Medical Association's
1996 Mid-Winter Seminars and Scientific Conferences

January 18-21, 1996

Charleston House - Holiday Inn
Charleston, West Virginia

We want to thank all of the participants of the WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences for their support which is vital for the continued success of this annual CME event.

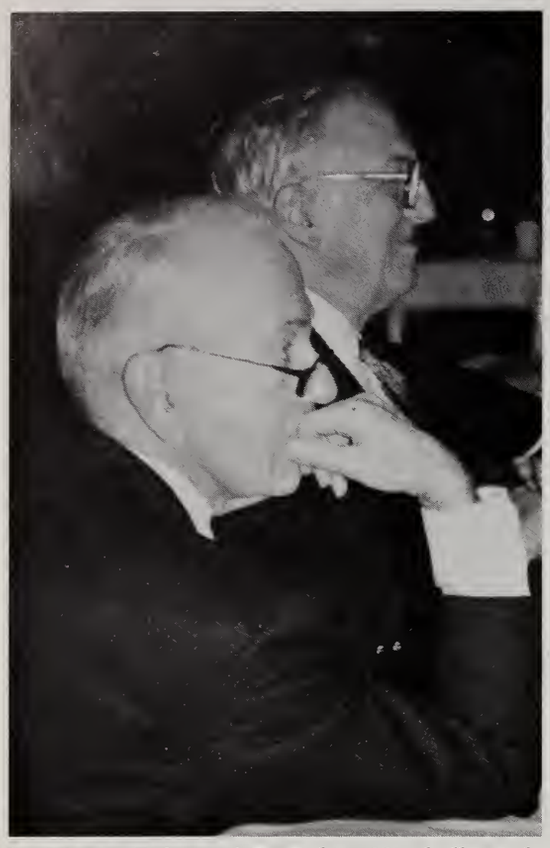
Dr. Derrick Latos, governor of the West Virginia Chapter of the American College of Physicians, and Dr. William Reynolds, president-elect of the ACP, proudly pose with Dr. Robert Marshall after he was presented with the WVACP's Laureate Award.

Senator Jay Rockefeller visits with WV Supreme Court Justice Joseph Albright, Speaker of the WV House of Delegates Chuck Chambers, and Dean of the Marshall School of Medicine Dr. Charles McKown at the reception co-hosted by the WVU and MU Schools of Medicine.

Tamara Lively of Medical Assurance of West Virginia, Inc., and Gay Jackson and Beth Hammers of the Marshall University School of Medicine enjoy the delicious buffet at the reception co-hosted by WVU and MU.

Dr. Steven Jubelirer, the program chairman of the WVACP's meeting and member of the WVSMA's Mid-Winter Program Committee, listens intently to Dr. Robert Hoeldtke's lecture for the First Scientific Session.

Before the start of the Physician/Public Session on *"Tort Reform and Product Liability Legislation,"* special guest speaker Senator Jay Rockefeller speaks with WVSMA President Dr. James Helsley, who moderated the session.



Dr. Warren Point and Dr. Robert Marshall watch closely as a guest speaker presents a challenging study for the *"Stump the Audience"* segment they facilitated during the Fourth Scientific Session.

Gubernatorial candidate Dr. Wallace Johnson of Beckley shares some humorous political insights with WVSMA President-Elect Dr. Ronald Cordell.

Following his lecture entitled *"Day Surgery without Disability, Expanding List Sans Laparoscopy,"* Dr. Walter Ledet of Sulphur, La., discussed his innovative surgical techniques with several members of the audience.

Dr. Mark White of Fayetteville stands at one of the microphones to ask Dr. Ronald Hrebinko a question during the Second Scientific Session.

An outstanding Lunch and Learn program on domestic violence was presented by Devika Malhotra, professor of sociology at WVU-Parkersburg, and guest panelists Debra Sizemore, M.S.W.; Penny Byrnside, R.N.; and Maureen Conley, J.D.; who assist victims of domestic violence. WVSMA President Dr. James Helsley moderated the program.

The presentation of Mountaineer Doctor Television in the Exhibit Hall was a popular attraction at this year's meeting. Here, Dr. Robert D'Alessandri, dean of the WVU School of Medicine (right), Dr. Daniel Foster, program chairman of the WVSMA's Mid-Winter Program Committee, and Dr. Jim Brick, who also serves on the Mid-Winter Program Committee, answer participants' questions about the system.

Eric and Gary Schwartz of McLain Surgical Supply, Inc., demonstrate some of their company's new equipment to Dr. Jim Lane at their exhibit booth.

Jim Woody, governing council for the AMA's Medical Student Section, addressed the members of the WVSMA's Medical Student Section at their annual meeting. *(See p. 112 for more pictures from the WVSMA-MSS Annual Meeting.)*

Dr. Victor Salutillo was the lucky recipient of several of the door prizes which were donated by the exhibitors and the WVSMA. Pictured with him is Dr. Daniel Foster, chairman of the WVSMA's Mid-Winter Program Committee.

Attorney Stan Starnes was one of the featured speakers at the Loss Prevention Seminar offered by Medical Assurance of West Virginia, Inc., on Thursday, January 18, prior to the start of this year's meeting.

Carolyn Atkinson, wife of Dr. Bill Atkinson; Dr. David Hess; and Nancie Albright, WVSMA associate executive director; had a great time singing *"Delilah"* at the laser karaoke competition.

Accomplished singer Dr. Jun Neri wowed the audience with his version of *"My Way."*

The Nancy Sinatra classic, *"These Boots Were Made For Walking,"* was revived by the talented sixsome of Joseph Albright, husband of WVSMA associate executive director Nancie Albright; Dr. David Hess; Dr. Bill Atkinson; Linda Elliott, president of the WVSMA Alliance; Tim Allman, WVSMA director of operations; and Carolyn Atkinson.

WESPAC Chairman Dr. Doug McKinney gets into the act at the laser karaoke competition.

Dr. Lalip Agarwal selected the song *"I Never Promised You A Rose Garden"* for his karaoke performance.

WVSMA Alliance President Linda Elliott puts her heart and soul into *"Those Were the Days."*

Host Dr. Rano Bofill (far right) and the judges, Lois Cashdollar of Medical Assurance (second from left), Bev Ellzey, wife of Chuck Ellzey of Medical Assurance (fifth from left), and Tamara Lively of Medical Assurance (second from right), posed with the winners of the laser karaoke and dance competitions: Art and Dr. Ida Jasmin and their daughter, Summer; Nancie Albright, WVSMA associate executive director; Jennifer Sebert, daughter of Dr. Steve Sebert; and Shela Neri, daughter of Dr. Jun Neri.

A Special Thank You to

Rano S. Bofill, M.D.

Thank you for providing a night of funfilled entertainment with laser karaoke and numerous dance contests. Hats off to you for a tremendous job!

This event was part of the 1996 Mid-Winter Seminars and Scientific Conferences and was hosted by Acordia of West Virginia and Medical Assurance of WV.

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The 1996 West Virginia State Medical Association
Annual Meeting is Coming Soon

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"Medical Licensing Boards & the Practicing Physician"

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- Tournaments
- Receptions and Entertainment
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Scientific Topics Include:

- *"Graduate Surgical Education - At Risk,"* ***T. L. Harris Address*** Gordon F. Murray, MD
- *"Marfan's Syndrome,"* Gordon F. Murray, MD
- *"Interventional Cardiology: Promises Fulfilled?"* Kenneth M. Kent, MD
- *"Office Evaluation of Children with Suspected Heart Disease,"* William A. Neal, MD
- *"Antibiotic Overview,"* Joseph Talley, MD
- *"TPA and Other Treatments,"* Stafford G. Warren, MD

Please be sure to make hotel reservations early by calling (800) 624-6070. For more information about other hotels in the area, contact the WVSMA at (304) 925-0342. For your convenience, you may register for the conference by calling the above number and using your Visa or MasterCard.

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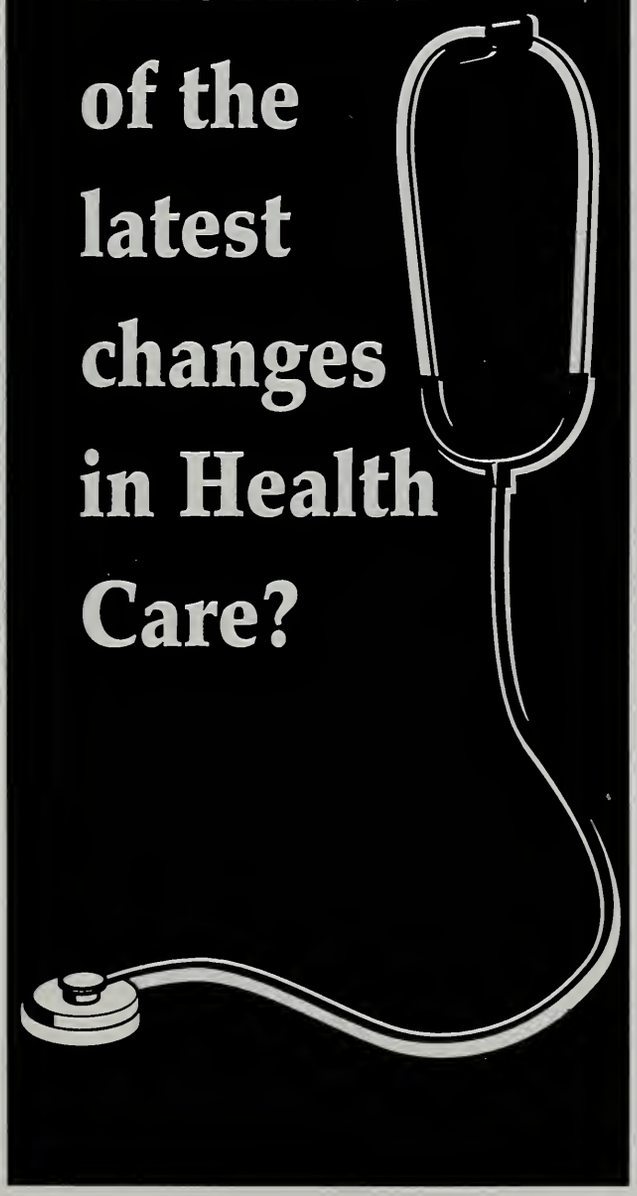

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Mini-internship program enters fourth year

Mini-internship programs, which provide community leaders with a firsthand look at health care delivery, have been gaining in popularity with WVSMA's component medical societies since Kanawha Medical Society launched the first mini-internship in West Virginia in February 1993.

The most recent component society to create a mini-internship is the Parkersburg Academy of Medicine, whose members began their program with an orientation breakfast for physicians and interns on January 4. This breakfast gave participants the chance to get acquainted with the physician they would be interacting with for one or two days. Dr. Harry Shannon, president of the Parkersburg Academy of Medicine, was very pleased with the program's success.

"We tried to make it convenient for interns to participate, especially the legislators, by giving them the choice of spending either one or two days with their physician," Dr. Shannon explained. "This made it much easier for them to work the internship into their busy schedules. Initially, many of the interns said they didn't have the time to commit two days to the program. However, after completing their internships, most participants indicated that the program was so worthwhile, they wished it had lasted longer."

Senate Minority Leader Donna Boley was one of the interns who echoed Dr. Shannon's comments.

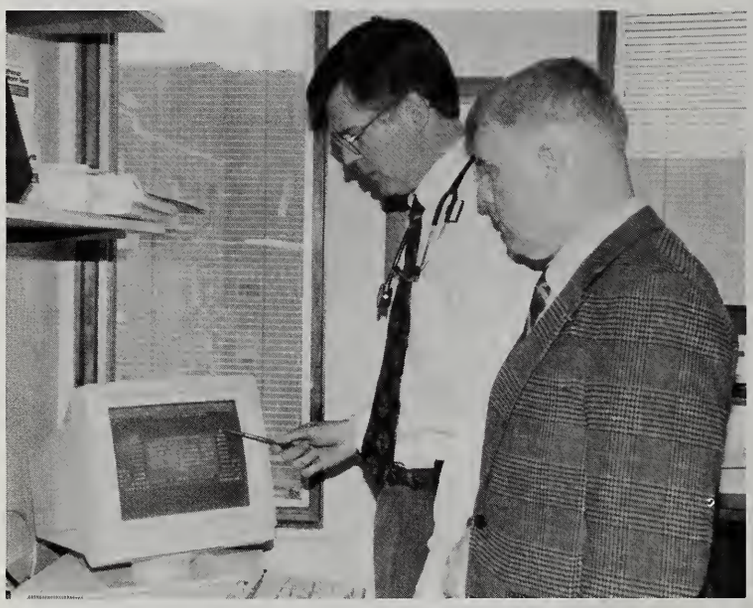
"I wish I had been able to devote more time to the program because it was such a great experience," Boley said enthusiastically. "Even though I was able to only spend about four hours with ob/gyn Dr. Rutherford Sims, I learned so much that I would recommend this program to anyone. I've always been squeamish at the sight of blood, so it was amazing to me that Dr. Sims could talk me through two hysterectomies and the completion of a Caesarean section without me feeling faint or sick. He was so calm, though, that now I feel I can handle anything. Not only have I developed a new respect for doctors and nurses, but I have gained insights into medicine which have been very valuable to me in my role as a legislator," she added.

The other interns who participated in the Parkersburg Academy of Medicine's program included: Dave Owen, editor of the *Parkersburg Sentinel*; Greg Smith of Blue Cross/Blue Shield; Delegates Tom Azinger, Otis Leggett, Ed Kime, J.D. Beane, and Larry Border; and Senator Frank Deem. The other physicians who participated were: Loretto Auvil, M.D.; David Avington, M.D.; Paul Burke Jr., M.D.; David Byler, M.D.; Stephan Hanna, M.D.; Barry Louden Jr., M.D.; Frank Schwartz, M.D.; David Avery, M.D.; and Jesse Ada, M.D.

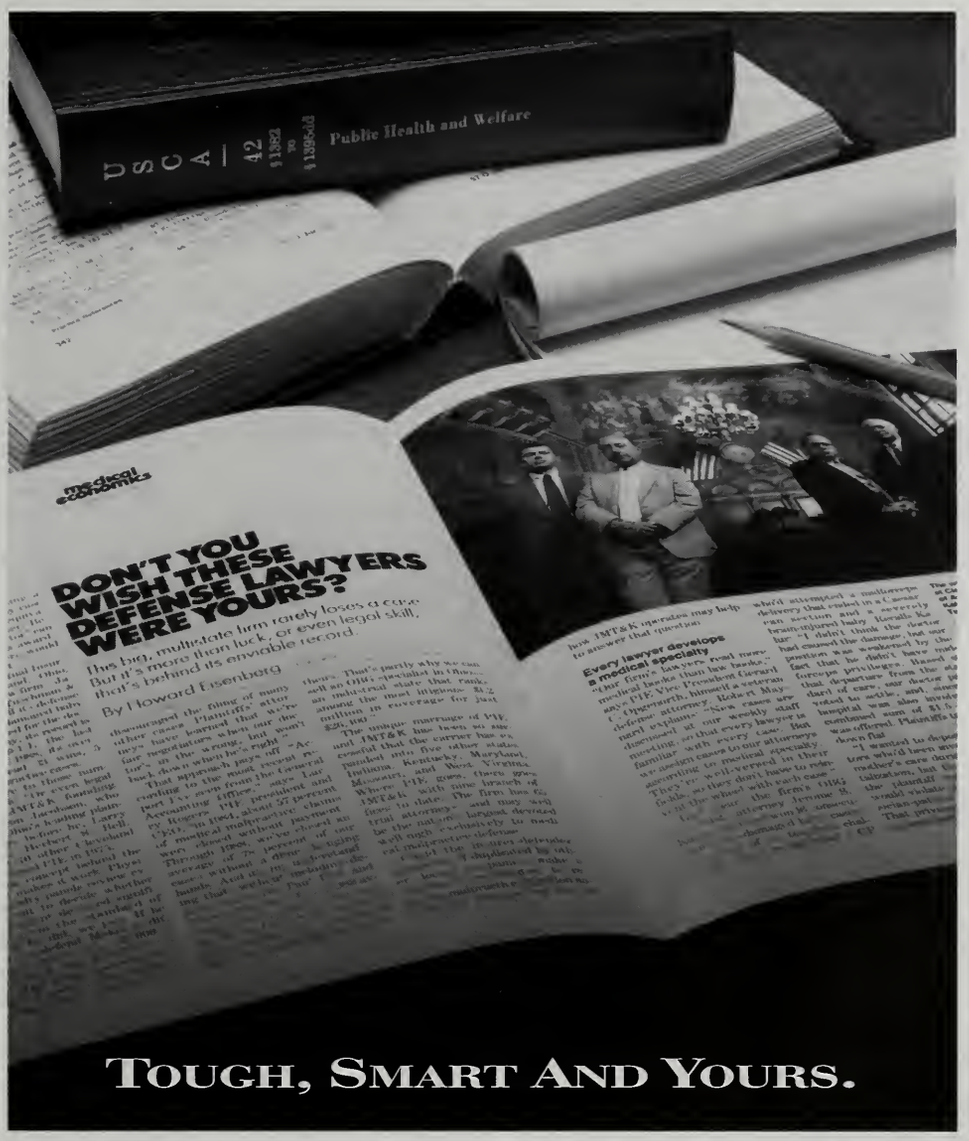
Many of the component societies now have internships on an annual basis. Kanawha Medical Society is now planning its fourth mini-internship, and Cabell County Medical Society and Ohio County Medical Society will hold their third programs this year. If your component society has held or will be coordinating a mini-internship program, please send a list of your participating interns to: Michelle Ellison, Public Relations Manager, WVSMA, P.O. Box 4106, Charleston, WV 25364.

For more information about how your medical society can develop a mini-internship, contact Michelle Ellison at (304) 925-0342.

Through his mini-internship with the Parkersburg Academy of Medicine, Delegate J.D. Beane gained an inside perspective into the daily life of family practitioner Dr. David Avery. Pictured with them is Tracie L. Dilliner, R.N., M.S.N., C.F.N.P.



Dr. Stephan Hanna of Parkersburg explains his computer system to Delegate Ed Kime, who spent time with him as part of his mini-internship.



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The distribution of West Virginia women targeted for screening of breast and cervical cancers

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Abstract

The primary strategy for the control of female breast and cervical cancers is early diagnosis and treatment from periodic screenings. To effectively provide screenings, it is important to target the populations that especially need these services. Based on state health objectives and an analysis of data from the 1990 Census, about 33% of the women in West Virginia are targeted for routine screening for breast cancer by clinical breast examination and mammograms, while about 77% are targeted for routine screening for cervical cancer by the Papanicolaou test. Since the racial and age distributions of women vary across Public Health Management Districts in the state, it is critical to determine the exact extent of breast and cervical cancers in West Virginia for geographic and other populations of women. In addition, the results demonstrate a need for age-adjustment when comparing measures of the cancers across geographic areas.

Introduction

Cancer of the breast is the most commonly diagnosed cancer among women registered in the nation's Surveillance, Epidemiology and End Results (SEER) program and the second leading cause of death from cancer among women (1). Additional data from the SEER program shows that invasive cancer of the cervix uteri is the third most common malignancy of the female genital system and the mortality rate from cervical cancer is more than twice as high for black women than for white women (1).

In order to effectively provide screening services that reduce the risk for mortality from breast and cervical cancers, the populations of women that should be targeted for such services must be identified. Based on guidelines from state and national health objectives and data from the 1990 Census of Population and Housing (1990 Census), this article characterizes the distributions of West Virginia women who are targeted for screening of breast and cervical cancers.

West Virginia's statistics

Data from the West Virginia Cancer Registry (WVCR) indicates that cancer of the breast is the most common primary cancer diagnosed among the state's women ages 25 years and older, and that it is the leading cause of cancer-related deaths among women ages 25 to 44 years as well as the second leading cause of cancer-related deaths among those women ages 45 years and older (2). State-specific data reported by the SEER program shows that the age-adjusted mortality rate for female breast cancer in West Virginia during 1987-1991 was 36th highest among the 50 states and the District of Columbia (1). Other published data indicate that breast cancer mortality rates in West Virginia are similar to rates of U.S. women as a whole (2)

Cervical cancer is the second leading cause of cancer among West Virginia women ages 25 to 44 years, the fifth leading cause among all women in the state, and the third leading cause of cancer-related deaths among those women ages 25 to 44 years (2). State-specific data reported by the SEER program show that West Virginia ranked seventh highest among the 50 states and the District of Columbia in age-adjusted mortality rates from cervical cancer during 1987-1991 (1). Several other studies have confirmed that cervical cancer mortality rates are greater for West Virginia than in the U.S. as a whole (2).

Although the WVCR has published district-specific information on the stage of cancer diagnosis, the state's county- or district-specific rates of cancer incidence and mortality are not currently available from a population-based surveillance system such as the WVCR (2,3). Geographic rates of disease incidence and mortality can be difficult to obtain because of the lack of appropriate denominators (i.e., population estimates) for composing the rates. In addition, geographic rates can include wide confidence intervals and other statistical imprecision that complicate the interpretation of the rates. Nevertheless, the assessment of the burden of breast and cervical cancers at all geographic and population subgroups is recommended in the National Strategic Plan for the Early Detectiton and Control of Breast and Cervical Cancers (4).

Early detection and treatment

Breast cancer is not considered a disease amenable to prevention through personal and community-wide efforts (e.g., primary prevention) (5). Given the current state of cancer detection methods, breast cancer screening provides the best opportunity for reduced mortality through early detection and timely treatment (secondary prevention) (6). Indeed, early detection and timely treatment offer a much greater chance of patient survival than detection and treatment at later stages (1,6).

Research indicates that mortality from breast cancer can be reduced by 30% among women ages 50 and older through clinical breast examination and mammography (7). Breast cancer mortality also may be reduced among women ages 40-49 who receive these examinations, but the results of

randomized clinical trials are inconclusive for these women (7). The optimal frequency for screening remains to be determined (7,8,9); yet there is general agreement on the need for mammograms every one to two years after age 50 (7).

In contrast, cervical cancer can be prevented through screening for precancerous, dysplastic lesions when accompanied by proper follow-up and treatment. The Papanicolaou (Pap) test is effective in reducing the risk for mortality from cervical cancer by as much as 75% (7). In the U.S., current recommendations of various government and professional groups leave the frequency of screening to the discretion of the physician, although all groups suggest an interval of one to three years for women ages 18 and older (7,10).

Health objectives

By the year 2000, state health objectives seek to increase the proportion of West Virginia women who receive a clinical breast examination and screening mammography for breast cancer and a Pap test for cervical cancer (11).

Specifically, the health objectives seek to:

(1) Increase to at least 80% the number of West Virginia women ages 40 and older who have ever received a clinical breast examination and a mammogram;

(2) Increase to at least 60% the number of women ages 50 and older who have received these tests within the preceding two years;

(3) Increase to at least 95% the number of women ages 18 and older who have ever received a Pap test; and

(4) Increase to at least 85% the number of women ages 18 and older who have received a Pap test within the preceding two years.

These objectives for West Virginia are similiar to national health goals for the year 2000 (7,12,13). In addition, the national objectives especially target Hispanic women, women with low-incomes, women with less than a high school education, older women and black women.

Screening services utilization

Based on data from the state's Behavioral Risk Factor Survey (BRFS)(13), the percentage of West Virginia women 40 and older who ever had a clinical breast examination and a mammogram increased from 55.7% (95% confidence interval [CI]: 52.1%-59.4%) in 1990 to 70.4% (95% CI: 67.3%-73.6%) in 1993. The percentage of the state's women 50 and older who had undergone the examinations in the preceding two years generally increased from 47.7% (95% CI: 43.4%-51.9%) in 1990 to 56.3% (95% CI: 52.2%-60.5%) in 1993. However, current data indicates that health objectives for breast cancer have not yet been met for women in West Virginia.

Furthermore, the percentage of women 18 and older in the state who ever received a Pap test was 93.2% (95% CI: 91.4%-95.0%) in 1993, while the percentage of those women who received the test in the preceding two years was 74.4% (95% CI: 71.5%-77.2%) (13). These estimates of Pap test usage have not substantially changed since 1990 when the statistics were 95.3% (95% CI: 93.9%-96.7%) and 76.1% (95% CI: 73.4%-78.9%), respectively. Hence, health objectives for cervical cancer also have not yet been met for women in the state.

Methods

To determine percentages of women targeted for screening of breast and cervical cancers, counts of West Virginia women from the 1990 Census were utilized (14).

Based on age guidelines from related state and national health objectives, the categories of women ages 40 and older and women ages 50 and older were used to characterize women targeted for screening of breast cancer (i.e., receipt of a clinical breast exam and a mammogram). The category of women 18 and older was used to characterize women targeted for screening of cervical cancer via Pap tests. In addition, county-specific data from the 1990 Census were aggregated to examine the racial distribution and the age distribution of West Virginia women across the Public Health Management Districts in the state (Figure 1). Since the statistics were from a decennial enumeration of the state's population, no methods were applied to determine statistical inference.

Results

Women comprised 52% (931,941) of the 1,793,477 people counted in West Virginia for the 1990 Census. Of these women, 76.9% (716,625) were

Figure 1. Public Health Management Districts in West Virginia.

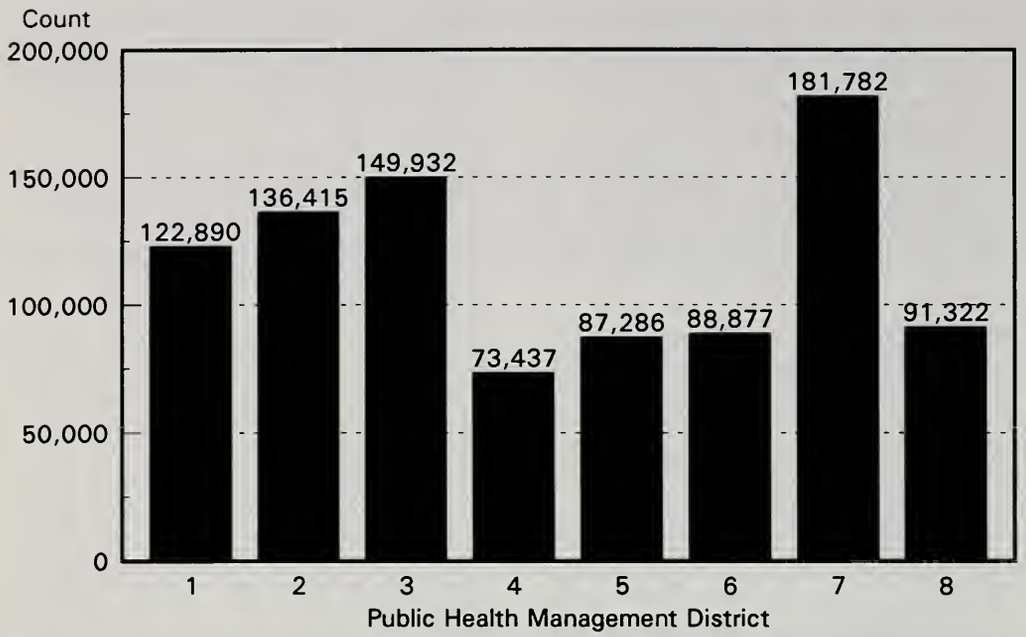


Figure 2. Count of West Virginia women by Public Health Management Districts (1990 Census of Population and Housing).

18 years and older; 45% (419,315) were 40 and older; and 32.5% (302,940) were 50 and older. Women were not evenly distributed across Public Health Management Districts in the state (Figure 2); for example, the count ranged from 73,437 in District 4 (7.9% of the women in the state) to 181,782 in District 7 (19.5% of the women in the state).

Although about 96% of the West Virginia population were white (14), the racial distribution of women varied greatly across the districts (Figure 3). For example, the proportion of black women ranged from 0.4% in District 5 to 7.4% in District 1. The age distribution of West Virginia women also varied across the districts in the state (Figure 4). For example, Districts 6 and 8 had similar counts (Figure 2), but District 6 had the lowest proportion of women who were under 18 (21.7%) and the highest proportion of women ages 50 or more years (35.6%) among the districts (Figure 4), while District 8 had the highest proportion younger than 18 years (24.3%) and the lowest number of women who were 50 or older (29.4%). Nevertheless, the category of women ages 40-49 years had the least variance among the age categories across the districts, with a range of 12.1% in District 7 to 13.2% in District 5.

Discussion

Based on year 2000 goals for screening participation and analyses of data from the 1990 Census, about 33% of the women in the West Virginia are 50 or older and thus are targeted for routine screening by clinical breast examination and mammography. In addition, about 77% are 18 or older and targeted for routine screening by the Pap test. However, since women are not evenly distributed across Public Health Management Districts in the state, and their racial and age distributions can vary, these results underscore the need to determine breast and cervical cancer incidence and mortality in West Virginia for geographic and other populations of women.

Due to the variability in the age distribution across districts, statistical adjustment for age will be necessary when comparing measures of cancer incidence and mortality. Age-adjustment (or age-standardization) is commonly applied to minimize the effects of differences in age composition when comparing rates for different populations (15,16). For example,

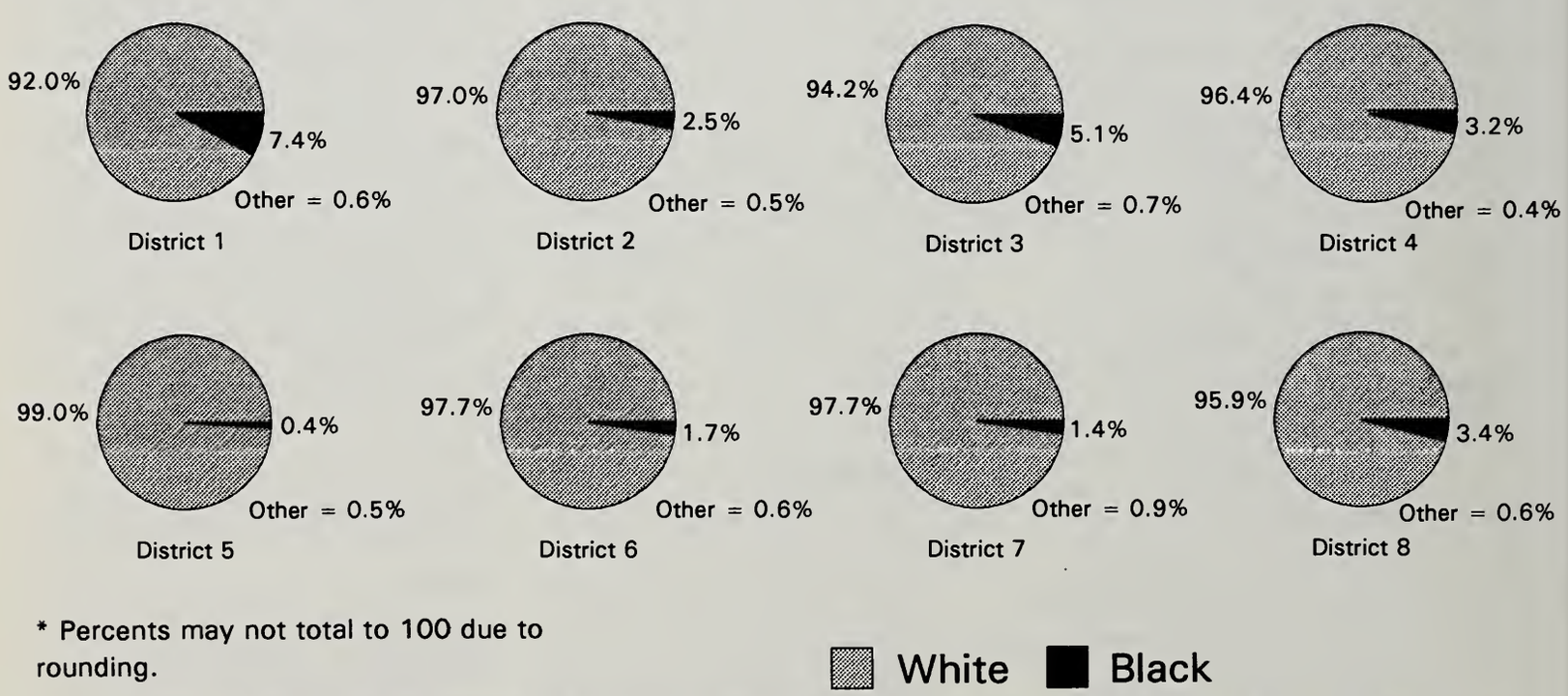
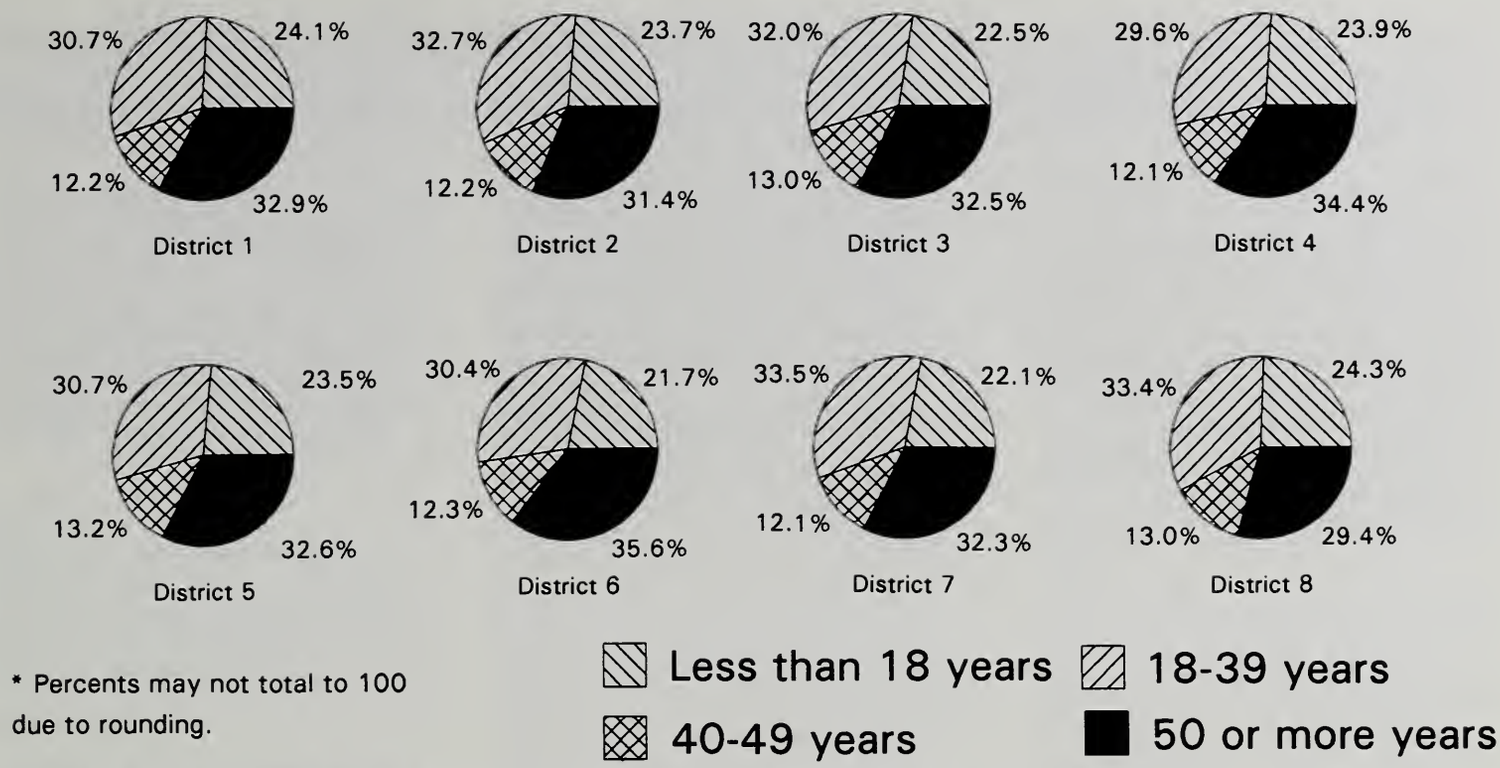


Figure 3. Racial distribution* of West Virginia women by Public Health Management Districts (1990 Census of Population and Housing).



* Percents may not total to 100 due to rounding.

Figure 4. Age distribution* of West Virginia women by Public Health Management Districts (1990 Census of Population and Housing).

without standardization for age, geographic differences in the percentage distribution of early diagnosed female breast cancer in West Virginia could be attributed to geographic differences in the age distribution of women in the state.

The 1990 Census is the nation's 21st consecutive decennial enumeration (17). A limitation to data from decennial enumerations of the U.S. population is undercount, which is the difference between the true population size and the census count (18). There are indications, however, that the data for the analyses in this article are less affected by undercount than are other data from the 1990 Census. For example, based on demographic analysis (19), the undercount of men was higher than that for women, and based on data from the 1990 Post-Enumeration Survey (20), the estimated rate of undercount in West Virginia (1.4%) was lower than the median of state-specific estimates of undercount rates (1.7%).

Another limitation to the analyses in this article is the use of only age to categorize women who are targeted for screening services. For example, elderly, poor, and minority women are least likely to be screened for breast and cervical cancers (4,7). Since year-to-year transitions into and out of poverty can be dynamic (21), data other than the 1990 Census would be required to characterize West Virginia women who are currently in poverty. However, my analyses characterize the distribution of West Virginia women who are targeted for breast and cervical cancer screenings and provide direction for study of the burden of female breast and cervical cancers in the state. Epidemiologic data (e.g., geographic rates of incidence and mortality, etc.) from the WVCR can be used to determine the need for public health action and to ascertain the effectiveness of cancer intervention programs.

The West Virginia Breast and Cervical Cancer Screening Program is part of the state's Department of Health and Human Resources, and is supported by state and federal funding to provide early detection screening and referral services for these cancers (22). Special emphasis is placed on the participation of older women who have low incomes, are uninsured, underinsured, or of minority status (22). West Virginia's program participates in the National Breast and Cervical Cancer Early Detection Program, which is coordinated by the U.S. Centers for Disease Control and Prevention. Efforts by this program and other health care professionals in West Virginia are needed to ensure that all women in the state, for whom it is deemed appropriate, receive regular screening for breast and cervical cancers, prompt follow-up if necessary, and certainty that tests are performed in accordance with current recommendations for quality assurance.

Acknowledgements

The author gratefully acknowledges the assistance of Nancye Bazzle, M.P.H.; Laurie Anderson, Ph.D, M.P.H.; Daniel S. Miller, M.D., M.P.H.; and Fred King in preparing this manuscript.

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The difficult diagnosis of subdural empyema: Report of three cases and review of the literature

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Abstract

Subdural empyema remains a frequently misdiagnosed clinical entity. This article presents three cases of subdural empyema and a review of recent literature.

Introduction

Subdural empyema (collection of purulent material in the potential space between the intracranial dura and arachnoid mater) is a rare entity which is often difficult to diagnose. Otolaryngologic infections, most notably extensions from the paranasal sinuses, have been reported to be its most common cause (1). According to a recent series, these underlying infections appear in as many as 70% of cases of subdural empyema (2).

Initial signs and symptoms of subdural empyema include headache, nausea, vomiting, meningismus, and fever with or without evidence of an otolaryngologic infection. If there is a delay in presentation or diagnosis, the symptoms may progress to altered mental status, focal neurological deficits, or generalized seizures (3). Initially, these symptoms mimic the presentation of other underlying neurologic entities and CT may be non-diagnostic. As a result, there is often a delay in diagnosis of subdural empyema and it is often first treated as bacterial or viral meningitis (4).

This article describes our experiences caring for three patients with different histories, but similar symptoms, who were found to have subdural empyema at the time of craniotomy.

First case

A 14-year-old girl was admitted to Charleston Area Medical Center, General Division, after experiencing a headache for five days, and neck pain, difficulty ambulating and speaking for two days. She had a seizure on admission.

Upon presentation, she had a Glasgow Coma score of 10, was febrile, aphasic, and had a right hemiparesis. There was no acute sinusitis on exam and her initial CT was unremarkable. Due to the fever and leukocytosis of 28,000, the diagnosis of meningitis was entertained. An LP was performed which showed 10 rbc, 85 neutrophils, 9 lymphocytes, a protein of 129 and glucose of 63.

Following LP, this patient became febrile and was started on intravenous antimicrobials, but she continued to deteriorate so a repeat CT with contrast was performed the evening after admission. This CT revealed a frontal epidural and left subdural low density mass with interhemispheric extension (Figure 1), and a small amount of left maxillary sinus disease was also noted. She subsequently underwent bifrontal craniotomy with evacuation of the epidural and subdural/interhemispheric empyema. Streptococcus intermedius and S. morbillorum were cultured from her purulent fluid collections.

This patient did well postoperatively with total resolution of her neurological deficits. At three months postcraniotomy, she was neurologically normal with no evidence of recurrence.

Second case

A 19-year-old white male was brought to the Emergency Department after being in a car accident in which he had not worn his seatbelt. He had a right-sided periorbital edema and ecchymosis from a closed-head injury and his right ankle was fractured. There was no rhinorrhea, but CT revealed a cribriform plate fracture.

By his third day of admission, this patient developed a fever of 38.5. On the fifth day in the hospital, he developed a headache, and by the following day became agitated with a left-sided hemiparesis and meningismus. His temperature rose to 39.2 with accompanying leukocytosis, and a repeat CT showed a small area of pneumocephalus in the left frontal lobe that was attributed to the cribriform plate fracture. There was no evidence of a fluid collection or shift, but right-sided, pan-sinusitis was also noted with a possible periorbital abscess.

An LP was performed which revealed 40 rbc, 69 neutrophils, 27 lymphocytes, a protein of 150, and a glucose of 65. This patient was felt to have meningitis secondary to the cribriform fracture and was immediately started on intravenous antimicrobials. He initially showed signs of clinical improvement with some resolution of his neurological symptoms, but five days after the intravenous antibiotics had been instituted, he again developed a leukocytosis reaching 48,000.

His maxillary sinuses were tapped and purulent fluid for culture obtained. Another CT scan was performed which revealed a subdural fluid collection and evidence of an intracerebral abscess (Figure 2). He then underwent a large bifrontal craniotomy with evacuation of the subdural empyema. Following surgery, he defervesced and his leukocytosis resolved with significant improvement of his neurological deficits.

A follow-up CT revealed enlargement of the intracerebral abscess which was successfully drained stereotactically. Despite his rocky clinical course, this patient did well postoperatively at home without obvious neurological deficit.

Figure 1. (Case 1) Axial enhanced CT image showing frontal and parietal subdural empyema.

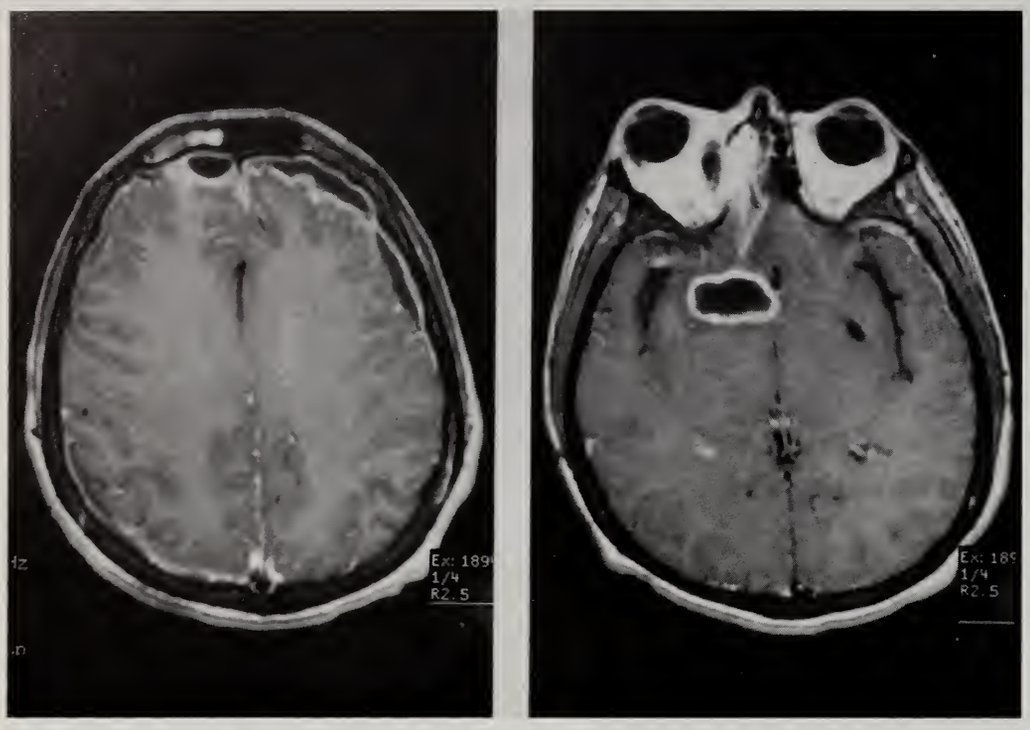

Figure 2. (Case 2) Axial enhanced CT image showing frontal and parietal subdural empyema (left) and brain abscess (right).

Figure 3. (Case 2) Axial enhanced CT image indicating parietal subdural empyema (arrows).

Third case

A 15-year-old boy was admitted to Charleston Area Medical Center, General Division, with a gradual onset of lethargy progressing rapidly to stupor over a course of 24 hours. He had recently undergone exploration and drainage of a frontal sinus abscess. A CT scan revealed both air and a frontal subdural collection consistent with subdural empyema (Figure 3).

At surgery, a large left frontotemporal craniotomy was accomplished with evacuation of the subdural empyema. This patient was continued on antibiotics and subsequently underwent a second craniotomy for an interhemispheric fissure abscess. He then defervesced, improved neurologically and was able to be discharged home where he has remained alert and oriented. He returned to school, but he has a persistent seizure disorder.

Discussion

Subdural empyemas are surgical emergencies requiring prompt drainage, but diagnosis is often difficult. Many cases, as illustrated by these three adolescents, are often initially diagnosed and treated as meningitis or sinusitis. Often the CT may appear normal early in the course of subdural empyema (5). Recent literature suggests that magnetic resonance imaging is superior to CT in demonstrating the presence and extent of subdural empyemas (6). One reason for the difficulty in demonstrating subdural empyema by CT may be that the neurological deficit is a result of local cerebral inflammation, vasculitis, and septic venous thrombosis, thus not by mass effect. The mass effect of the empyema is usually small and therefore difficult to detect by conventional CT.

If left untreated, the venous thrombosis leads to local edema and infarction which eventually results in transtentorial herniation and death. In the literature, both CT-directed, burr hole drainage and craniotomy have been advocated (8). However, recent study suggests that initial craniotomy is the method of choice resulting in fewer recurrences with improved morbidity and mortality (1).

In conclusion, it must be stressed that although an uncommon entity, subdural empyema must be considered in patients with an altered mental status and fever, or with a presumed meningitis unresponsive to conventional treatment.

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Enhanced limb salvage for peripheral vascular disease with the use of spinal cord stimulation

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Abstract

For patients with peripheral vascular disease that have exhausted all means for surgical repair, spinal cord stimulation is an alternative treatment that could offer them significant pain relief or possibly delay the need for limb amputation. Spinal cord stimulation (SCS) has proven to offer many of these patients a return to a more normal lifestyle by relieving pain to such a degree that their mobility is improved. In addition, increases in blood flow to the affected extremity have helped to improve overall foot salvage. Since SCS is minimally invasive and has few reported complications, it is a viable alternative for patients with multiple health risks, and with proper patient selection and early referral, it can reduce health care costs in many cases.

Introduction

Peripheral Vascular Disease (PVD) is a progressive process which, in its final stages, causes excruciating pain and often the loss of a limb. Vascular surgery has provided the only avenue for improving these patients' symptoms and chances of saving their limbs, and reconstructive vascular surgery is today's best method for treating severe PVD. However, there are still thousands of patients who are not candidates for reconstructive vascular surgery either because of their general medical condition or their vasculature is not surgically correctable, which results in a tragic 60,000 amputations each year in the U.S.

For these patients with non-surgical, end-stage PVD and for those who continue to have leg or foot pain postoperatively, spinal cord stimulation (SCS) offers a means of enhancing limb salvage or it can possibly delay amputation for patients who are not surgically reconstructible. In addition, SCS can provide pain relief prior to an amputation and aid in the reduction of phantom limb pain.

In Europe, the use of SCS has been been very successful for many years, and PVD is probably the most common indication for spinal cord stimulator implantation. In the United States, failed back syndrome, peripheral neuropathy, phantom limb pain, and reflex sympathetic dystrophy remain the most common indications for implantation of spinal cord stimulators.

History of use of SCS for PVD

Over 90 years ago, Bayliss was the first to note that dorsal root stimulation enhanced the peripheral circulation in laboratory animals (1). Later, Foerster stimulated peripheral nerves to cause vasodilation so that he could map regional dermatomes (2).

In 1973, while using SCS to treat limb pain in patients with multiple sclerosis, Cook and Weinstein noted increased blood flow to the extremity being treated for pain (3). In 1976, Cook tried using SCS to treat nine patients with pain caused by PVD (4). He noted not only pain relief and increased blood flow, but also increased skin temperature and improved tissue integrity. He suggested that SCS might avert some amputations and should be investigated further. That same year, Dooley and Kasprak also noted that electrical stimulation to the spinal cord or dorsal roots caused significant arterial dilatation distal to the area stimulated (5).

All of these early clinical studies prompted animal research to understand spinal cord stimulation and its mechanisms. Hilton and Marshall demonstrated that antidromic stimulation of smaller afferent fibers caused muscle vasodilation (6). Lindroth and associates sought to demonstrate the mechanisms of vasodilation via SCS (7).

Although exact mechanisms are still uncertain, it seems likely that the resultant vasodilation from SCS is due to alteration of the sympathetic control of blood vessels. It has also been noted that this vasodilation still occurs in subjects with partial sympathectomy. This has been verified in animal experiments and in the clinical setting where subjects having had partial sympathectomy still demonstrate improved blood flow with SCS. In addition, over the past two decades, SCS has been used to provide pain relief for patients with ischemic pain in the limbs.

SCS implanting

The spinal cord stimulator is a simple device to implant which is non-destructive and, if necessary, can be removed with no residua. This procedure is performed in the operating room under sterile conditions to decrease the risk of epidural infection using intravenous sedation and local anesthesia.

SCS is accomplished with the use of a wire containing a series of conducting electrodes connected to an impulse generator similiar to the cardiac pacemaker. A temporary electrical lead is positioned in the epidural space through a 15-gauge Touhy needle placed in the lower lumbar area. Once in the epidural space, the electrode is advanced toward the head using fluoroscopy to determine the level of placement. The electrode is usually situated at a level between the T10-L1 vertebrae, inclined towards the side of the pain.

A screening pulse generator is then used and square wave voltage pulses are passed between two electrodes exciting neurons. This causes paraesthesia perceived by the patient. With proper electrode placement the parathesia will completely cover the painful foot or limb. The temporary electrode is used for a 3-7 day trial period, giving patients a chance to determine if the SCS is giving the patient sufficient pain relief and if the paresthesia is tolerable. If the patient reports greater than 50% pain relief, the SCS has an excellent chance of providing long-term analgesia and enhanced limb salvage. If the patient reports less than 50% pain relief initially, limb salvage is rare.

For many patients, limb salvage means continued independence. Elderly patients rarely remain independent following an amputation because about half never walk with a prosthesis (8). If the SCS is successful, patients will require few pain medications and therefore fewer drug

side effects. If the trial stimulation period is successful, the patient returns to the hospital to have a permanent lead placed epidurally. In addition, an implantable pulse generator (IPG) is placed in the subcutaneous tissue of the abdomen so stimulation patterns can be communicated via telemetry postoperatively. This phase is also done in the operating room with monitored anesthesia care.

Patient follow-up

The patient and family receive extensive education before the trial stimulation, during the trial period, and again with permanent implantation from physicians at the Pain Management Center. Early in the course of treatment, the pain team assesses the patient and family frequently for understanding and education in regards to the SCS system.

Postoperatively, patients are followed at a minimum of one week, one month, three months, and then every six months. If the patient or family are unsure or hesitant about the operation of the stimulator, teaching is done more often. Each patient receives a hand-held spinal cord stimulator programmer. He/she is instructed in ways to alter the amplitude and frequency of the pulses in order to correlate the stimulator output with changes in their activity. Initially, there is a steep learning curve for the patient and family.

As the patient gains confidence, he/she is seen less frequently at the Pain Management Center. However, return visits are scheduled every six months to monitor the system and its effect on the patient's pain. The primary care physician is kept informed of the patient's progress.

Complications

Even though SCS is minimally invasive and employs a non-destructive device, there are bound to be complications as with any medical appliance.

There is no reported mortality associated with SCS, but the most common problem that can occur is intolerance of the paresthesia. This is normally obviated by adjusting the stimulation being generated, however, there are rare occasions when a patient may not tolerate any stimulation whatsoever. The trial period excludes these patients from permanent implantation and further emphasizes why patient selection is so critical for successful SCS.

The next most frequent complication of SCS is mechanical breakdown. As with any mechanical device, equipment failure can occur. The devices most often used are manufactured by a company that has been producing cardiac pacemakers for decades. Not only is the equipment very dependable, but the support services are exceptional.

While lead migration may have been a problem with SCS early on, with progressive lead development and improved implantation techniques, its incidence has decreased. Of course, all of these factors vary depending on the physician's experience and expertise with SCS. As the awareness of this modality for treating endstage PVD increases, physician implanting techniques will continue to improve and physicians will cultivate the ability to select patients that will receive the most benefit from SCS.

Outcomes

What kind of results can one expect? Generally, with proper patient selection, careful implantation and comprehensive teaching, 100% of the patients with claudication and 75% of patients with pain at rest have adequate pain relief. Thirty percent of patients with pain at rest accompanied by ulcers or gangrene of their limbs have lessening of pain.

A review of the literature for SCS use in patients with PVD reveals excellent results. However, the lack of control groups is a serious problem. Also, there are widely varying degrees of vascular pathology in many of the groups studied. There is very little in the literature to demonstrate the natural history of PVD once pain is present. Humphries looked at severe ischemia in the lower extremity and suggested that without treatment, 34% of the patients with ischemic pain would avoid amputation in the following year (9).

Patients with ischemic pain can be subdivided using the Fontaine classification which is widely used in the vascular literature. Fontaine's Stage III consists of patients with ischemic pain at rest, and Stage IV patients are those with ischemic pain at rest who, in addition, have non-healing ulcers or gangrene. Humphries' article reveals that Stage III patients have a 51% foot salvage in the ensuing year while Stage IV patients have only a 17% foot salvage. Table 1 shows a brief review of the various authors' success rates in utilizing SCS to salvage patients' feet. All of these results indicate that foot salvage overall is twice as good with those patients given SCS. In patients with Stage IV disease, the foot salvage is improved approximately threefold.

Our experiences implanting 12 patients with severe PVD who were not surgically reconstructible have been similiar to that of these other authors. Most of our patients had prior vascular surgery and were still experiencing ischemic pain. However, one patient was not referred to us until the amputation was impending, so we were not able to initiate SCS until the patient and the surgeon were actually deciding the level of amputation. We hoped that the amputation could be kept at a transmetatarsal level rather than lose the entire foot. However, the patient ultimately required a below the knee amputation, which points out the need for earlier intervention for SCS.

Table 1. Various authors' success rates at utilizing SCS to save patients' feet from amputation.

Author	Year	# Patients in Study	% Patients Stages III & IV	Foot Salvage Stage III	Foot Salvage Stage IV
CONTROL					
Humphries	1963	475	34%	51%	17%
SCS TREATED					
Augustinsson	1985	34	62%	100%	57%
Broseta	1986	37	71%	95%	64%
Graber	1987	9	–	–	67%
Jacobs	1990	20	56%	67%	43%
Bunt	1991	15	80%	89%	67%
Claeys	1993	156	69%	82%	41%
Rickman	1994	25	68%	75%	62%
Lawrence	1994	35		78%	38%

Another patient in our study who required an amputation was also Fontaine Stage IV with a black third toe when she was first seen. SCS provided her with 10 months of pain relief. However, this patient returned and she had to undergo a below the knee amputation due to gangrene. Several months later, this patient died due to a cerebrovascular accident and hypertensive cardiovascular disease.

Our final results indicated we had 83% limb salvage, with 100% limb salvage in Fontaine Stage III and 67% limb salvage in Stage IV patients. These results are consistent with what has been seen throughout the U.S. and Europe. Unfortunately, our patient experience is small in this country because patients are rarely referred to pain clinics for ischemic pain. We hope that through education, physicians will become aware of this treatment modality and its benefits for patients with endstage PVD.

Discussion

Over the past two decades, various investigators have made important observations in using SCS for PVD, especially the fact that pain relief is the cornerstone of success in treating PVD (10). The other two major observations are that substantial pain relief correlates with foot salvage, and that blood flow increases only when pain is relieved (11).

Without pain relief, ulcers will deteriorate and eventually the patient will require limb amputation (12). Patients with ulcerations experience a 55% limb salvage (13), while those without ulcers have a 90% salvage. Ulcers greater than 3 cm are not likely to heal, and ulcers with joint involvement or intense epicritic pain will not respond to SCS.

Unless the SCS is being implanted for phantom limb pain, it is of little use to implant patients with wet gangrene because they will still require amputation. SCS implantation can be predicted to fail if the transcutaneous oxygen tension is less than 20 mmHG on the initial reading (14). Success is also unlikely to occur if the patient is not cooperative or motivated, or if the trial period yields less than 50% pain relief.

Conclusion

Patient selection is the key to successful SCS. Although it takes a substantial experience to understand proper patient selection, the following guidelines provide the characteristics which will be present in patients who will routinely benefit from SCS:

1. Chronic intractable pain secondary to ischemia of the limb which can be caused by arteriosclerosis (with or without diabetes), thromboangiitis obliterans (Buerger's disease), vasospasm (Raynaud's disease), or embolic occlusive disease;
2. Surgical reconstruction is no longer possible or the patient has endstage PVD;
3. Greater than 50% pain relief is provided during the trial period; and
4. Ulcers should not be greater than 3 cm.

Utilizing these criteria for successful patient selection, SCS offers not only pain relief but also increased blood flow. With increased circulation comes improved limb salvage, as well as increased exercise tolerance, the need for less narcotics, and a better quality of life. In addition, since most PVD patients implanted with SCS have fewer hospital admissions and doctor visits, managed care plans are finding SCS attractive as a means of containing health care costs for these patients.

Hopefully, this article will increase physicians' understanding of this modality so it can be applied early before ischemia takes its toll.

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Granuloma of the lacrimal sac

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Abstract

This article describes a rare case of granuloma of the lacrimal sac, which was treated with dacryocistorhinostomy and glabellar flap. In addition, the possible etiologic factors, the differential diagnosis and reconstructive techniques indicated in such cases are described.

Introduction

Granuloma of the lacrimal sac is a fibrovascular ingrowth of unknown etiology. It can cause obstruction of the lower lacrimal ducts. This obstruction is typically associated with some degree of lacrimal sac infection and may simulate a skin tumor. The differential diagnosis is difficult and the surgical approach of such lesions may require the reconstruction of the lacrimal pathway.

Case report

A 37-year-old man presented with a lesion proximal to the right medial canthus of one-year duration. The onset was insidious, beginning as an inflammatory reaction. He was treated with oral antibiotics and showed some improvement.

About five months later, this patient had a recurrence of the inflammation but of lesser severity. He was treated again with antibiotics and the process became localized. The patient denied any history of conjunctivitis, trauma, instrumentation of the lacrimal punctum or epifora.

His granduloma-type lesion was inflamed and raised, and measured 2 cm x 1.8 cm just below the right medial canthus (Figure 1). There was swelling of the surrounding skin but several cultures revealed no growth. Biopsy of the lesion diagnosed chronic inflammation.

The granuloma was completely resected up to the periosteum of the nasal bones and lacrimal sac. A vasoconstrictive solution was infiltrated in the turbinate. Using a drill and trephine, a 5 mm diameter window was opened in the nasal bone and nasal mucoperiosteum (Figure 2). The lacrimal sac could not be identified. A #2 prolene suture was passed from the lacrimal puncta to the nasal mucosa, to create a gravity draining conduit, and kept in place for six months.

The defect was then covered by transposition of a glabellar flap (Figure 3). Histopathologic examination showed connective tissue with acute and chronic inflammatory reaction, lacunar spaces covered by epithelial cells, without any signs of malignancy, compatible with chronic dacryocystitis and granulation tissue.

A follow-up after two years has shown no recurrence of the lesion or lagophthalmus.

Discussion

The lacrimal sac is a static structure that serves as a collecting sphere, but it may be forced to evacuate its contents into the nasolacrimal duct by the "squeezing" action of the orbicularis oculi muscle (1). It is the site of various pathological processes including congenital, traumatic, infectious, and neoplastic.

A granuloma is the most common type of growth in the lacrimal sac (2), and is thought to result from trauma and inflammation. The chronic process may induce a localized damage of the overlying epithelial basement membrane. It is followed by a fibrovascular ingrowth. In addition, there are also reports of granulomas occurring as a reaction to a retained foreign body such as dacryoliths, hair, plastic tube, or silicone tube.

The differential diagnosis includes all pathologies of the medial canthus region: sinusitis, dacryocystitis, trauma and tumors (Angiosarcoma, Kaposi sarcoma, squamous cell, lymphoma and metastatic). The confined position of the lacrimal sac behind the anterior lacrimal crest and several soft tissue layers is known to make the diagnosis of tumors in this area difficult (2). Symptoms include epiphora, blood-stained tears and localized swelling at the medial canthus (3,4).

The histopathologic exam will reveal a non-specific granuloma consisting of well-vascularized friable tissue of a myxomatous nature containing an infiltration of lymphocytes, plasma cells, and a few eosinophils, without evidence of any invasive infection (2). The term

Figure 1. View shows how the patient's granuloma of the lacrimal sac looks like a skin tumor.

Figure 2. Defect after resection. A probe is passing into the nasal cavity.

Figure 3. Postoperative view at two months.

"lobular capillary hemangioma" has been suggested to describe these lesions (5).

It is usually not possible to salvage the lower collecting system in a viable functional unit. The task is to bypass the lower collecting system and create an opening directly into the nasal cavity by surgically forming a fistula between the lacrimal sac and nasal cavity - - the dacryocystorhinostomy (6), as in the case we have described.

Even though the Pyrex conjunctivorhinostomy has been considered to be the most effective treatment method for patients with tear-duct dysfunction (7), this procedure can be plagued with problems of tube dislodgment and infection, requiring intermittent cleaning and manipulation (8). Tear-duct reconstruction utilizing a autologous vein or mucosal graft has also been advocated (9,10). Unsuccessful revascularization, however, may result in graft failure. Conjuntival mucosal flap singularly or in conjunction with a mucosal flap is designed to reconstruct a fistulous tract for tear drainage (11). In our patient's case, we used a suture passed through the two puncta to the nasal cavity and fixed in the nasal wall, which achieved good results and did not require further special care.

The skin coverage for this area can be obtained by forehead flaps (1), glabellar or cheek flaps. It is critical to use flaps that can assure perfusion and skin coverage to the new tear pathway.

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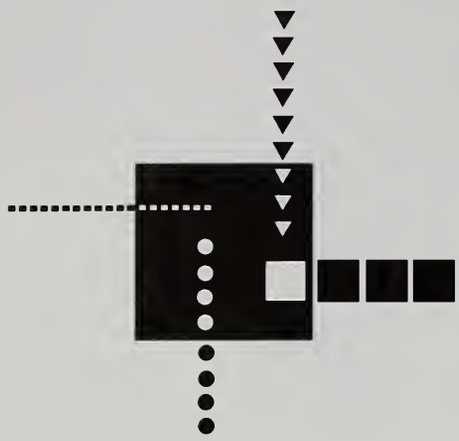
Organized Medical Staff Section



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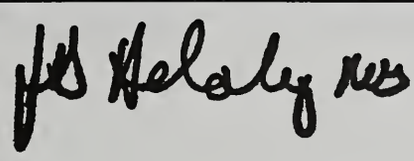
President's Page



Halftime

Editor's Note: Since the first half of his year as president is over, Dr. Helsley is offering these reflections:

- In corporate America, there is the continual focus on the "bottom line." Wall Street analysts, economists and stockholders all look at the bottom line, or net profit, when assessing a company's viability. In a sense, as the members of the WVSMA, you are the stockholders of this organization, and therefore, have a vested interest in our bottom line. While not likely to shock the financial world, I am pleased to report that the WVSMA ended 1995 with a surplus of $47,000. Compared to a $49,000 loss in 1994, this represents a nearly $100,000 turnaround in our bottom line. The lion's share of this turnaround came from a reduction of expenses instituted last year. The Executive Committee hopes for more savings in 1996 by empowering the Finance Committee to recommend further cost cutting where feasible.

- As new issues arise, facts are collected and distributed to the membership. A case in point is the PEIA formulary restrictions put into effect on January 1 which limit the coverage for non-steroidals to generic and also restrict the coverage for non-sedating antihistamines to only 90 days per year. (What about perennial allergic rhinitis?) These are just two of the surprising developments in the new PEIA prescribing rules which create unnecessary hardships for our patients, let alone increased cost and senseless pressure on the prescribing physician caught in the middle. As the full impact of this PEIA formulary develops, we will need to continue to communicate with our patients about their restricted therapeutic options.

- As the Legislature drew to a close, we saw the same serious horse trading we witness year after year. Why our senators and delegates find it necessary to play out this frantic, 11th hour drama, truly escapes me. I won't try to figure it out; however, rest assured that our staff members George Rider and Winnie Morano, have worked diligently to cover all the bases and look out for our best interests at the Capitol. We are fortunate to have these good people at bat for us, but it would be such a critical phenomenon if more and more physicians would visit the Capitol during the session and attend our Legislative Reception, so we could really make a significant impact at the Legislature. We have made major strides in the last few years, but politics is an arena that needs our constant attention.

- At the WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences in January, the WVSMA's Medical Student Section convened their annual meeting. I must say nothing pleases me more than to see concern, interest, and enthusiasm from our student members. From this early involvement in organized medicine should come a lifelong commitment to the profession and these future physicians are already doing an impressive job of promoting the House of Medicine. I find this quite heartening, and on behalf of the entire WVSMA, I want to congratulate our student members for their achievements.

James D. Helsley, M.D.

Please turn to the following page for a special message from Dr. Helsley about tort reform and the democratic candidates for the gubernatorial election!!!

Special Primary Election Alert!!!

Dear Colleagues:

The letter on the opposite page from nine trial lawyers speaks volumes as to who they think would give medical malpractice reform a fair hearing as governor.

The five tort reform proposals listed in the letter are the WVSMA's legislative program that we have sponsored for many years. Senator Manchin never had an opportunity to consider this legislative package in the Senate. That chamber has never dealt with the issue. However, the trial lawyers are convinced he would consider it as governor.

What more needs to be said! WESPAC, the WVSMA's political action committee is currently in the process of making gubernatorial, Supreme Court, and legislative endorsements. Since the Democratic primary is so important to the trial lawyers, it should be just as important to us.

For that reason, we, as physicians, must take action in addition to WESPAC to ensure that the trial lawyers' candidate does not win the Democratic primary. Senator Manchin needs your financial support NOW!!!

Sincerely,

James D. Helsley, M.D.
WVSMA President

P.S. Your support in the above situation is obviously very important. Of equal importance is your continued financial contributions to WESPAC so that we can endorse all candidates supportive of medicine's views.

Campaign For Justice '96

January 30, 1996

Dear Fellow Trial Lawyer:

West Virginia's Democratic Party Election for Governor is May 14, 1996 - just a little more than three months away. We believe that the race for Governor is simply a two-person race - Charlotte Pritt vs. Joe Manchin. You need to be acutely aware of how the people we represent will be affected and acutely aware of how devastated our profession would be by the election of Manchin as Governor.

First, it is quite clear that Manchin is backed by Big Business. The medical profession, manufacturers, and the business community have raised more than $1.2 million for him. We feel from past conversations with him and from his voting record that Manchin is committed to Draconian measures in the areas of product liability, medical malpractice, Mandolidis claims and other civil cases.

The medical association and the insurance industry have already submitted proposed legislation to all legislators. Here is part of the big business agenda:

1. Allow introduction of collateral source evidence (55-7-19). In all civil actions, the defendant would be permitted to introduce any benefit paid to the plaintiff as a result of an injury pursuant to the U.S. Social Security Act, state and federal Workers' Compensation Act, any disability, health, sickness, life, income disability, or accident insurance that provide health benefits or income disability coverage, etc.

2. Reduction of the statute of repose from ten years to six years in cases instituted against a health care provider regardless of when negligence is discovered.

3. Medical case claims screening (55-7b-13). This applies to medical professional liability and requires affidavits of an attorney that he has a written report reflecting that there is a reasonable and meritorious cause for filing such an action.

4. Periodic payments of awards for personal injury (55-7-18). This section abolishes the common law rule requiring that judgments be paid as a lump sum.

5. Limitation on attorney fees in civil actions wherein a party maintains insurance coverage (55-7-22). This particular legislation mandates a declining scale for attorney fees to a maximum of 15% on any amount on which the recovery exceeds $600,000. Obviously this legislation would be devastating.

The last public opinion poll taken, which we reviewed last week, still shows Charlotte Pritt with more than a 2 to 1 lead over Joe Manchin. She is the only viable candidate who has the opportunity to win this Governor's Race.. It is absolutely critical that we, as lawyers representing the injured and disadvantaged, raise sufficient funds to enable her to conduct an effective media campaign. Manchin has begun his "blitz" and we must now counter his media efforts.

CAMPAIGN FOR JUSTICE '96 is now in full swing. On behalf of our clients, you must join this campaign NOW. Write your check for One Thousand Dollars (or whatever else you feel you truly can afford) to Pritt For Governor and send it to Pritt for Governor Headquarters, PO Box 567, Charleston, WV 25322. We have already done so and we are determined to see CHARLOTTE PRITT elected GOVERNOR of the State of West Virginia. We need your help. Thanks.

Very truly yours,

Wesley W. Metheney
James C. Peterson
Pat Maroney
Frederick D. Fahrenz
Frank Venezia
Rudy DiTrapano
James Robinson
Guy R. Bucci
Linda Rice

At Annual Meeting

General Session to focus on subjects about heart diseases in adults, children

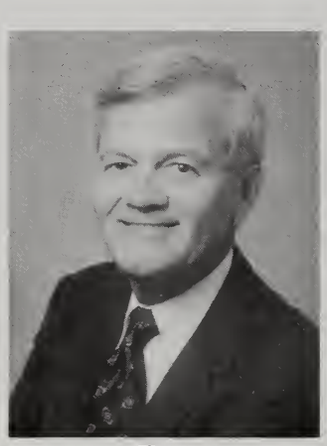
This year's General Scientific Session on Thursday, August 22 during the WVSMA's 129th Annual Meeting at The Greenbrier will feature four speakers who will lecture on subjects relating to the diagnosis and treatment of heart diseases in adults and children.

This session will begin 9 a.m. with a lecture entitled *"Marfan's Syndrome"* by **Gordon F. Murray, M.D.**, chairman of the Department of Surgery at the Robert C. Byrd Health Sciences Center of WVU in Morgantown. Then, at 9:30 a.m., **Kenneth M. Kent, M.D.**, director of Washington Cardiology Center in Washington, D.C., will speak on the subject of *"Interventional Cardiology: Promises fulfilled?"*

Following a break, the session will reconvene with a lecture on *"Office Evaluation of Children with Suspected Heart Disease,"* by **William A. Neal, M.D.**, professor and chairman of the Department of Pediatrics at the Robert C. Byrd Health Sciences Center of WVU in Morgantown. This session will then conclude with a discussion on non-surgical treatment of heart diseases by **Stafford G. Warren, M.D.**, clinical professor of medicine at the Robert C. Byrd Health Sciences Center of WVU, Charleston Division, and the Marshall University School of Medicine.

Brief biographical information about these four speakers begins below. For more meeting details, phone the WVSMA at (304) 925-0342.

Murray



Kent

Neal

Speakers highlighted

Dr. Murray was born in Muskegon, Mich., and received his M.D. from the University of Michigan in 1963. He completed general surgery and thoracic residencies at Massachusetts General Hospital and the Johns Hopkins Hospital.

A commander in the U.S. Naval Reserve, Dr. Murray served at the U.S. Naval Hospital in Great Lakes, Ill. His academic experiences include positions as professor and associate chief of thoracic surgery in North Carolina Memorial Hospital in Chapel Hill, N.C., from 1972-85, and his current posts as chairman of the Department of Surgery at the Robert C. Byrd Health Sciences Center of WVU in Morgantown and chief of surgical services at Ruby Memorial Hospital. In addition, Dr. Murray is presently cardiac surgeon-in-charge at Monongalia General Hospital in Morgantown.

Board certified by the American Board of Surgery and The American Board of Thoracic Surgery, Dr. Murray has distinguished himself nationally as an academic surgeon. He is a past president of the Southern Thoracic Surgical Association and the Thoracic Surgery Directors Association, and is chairman of the Examination Committee of the American Board of Thoracic Surgery.

Dr. Kent was born in Tifton, Ga., and received his M.D. degree from the Emory University School of Medicine in 1965. Upon receiving his medical degree, he remained at Emory to complete a National Institutes of Health Research Training Fellowship in the Dept. of Physiology and work on his Ph.D.

From 1967-68, Dr. Kent was an instructor in the Dept. of Physiology at Emory and then the following year served as an intern at Grady Memorial Hospital in Atlanta. He completed his residency in medicine at Emory University in 1969 and then became a clinical associate at the NIH in Bethesda, Md., for three years, during which time he earned his Ph.D. in physiology at Emory.

Dr. Kent was promoted to a senior investigator in the Cardiology Branch at NIH in 1972, and three years later he was named a consultant for the Cardiology Clinical Center at NIH. Dr. Kent then held administrative posts at NIH from 1975 until 1981, when he left to become a clinical associate professor of medicine at Georgetown University Medical Center.

After teaching at Georgetown for two years, Dr. Kent was elevated to director of the Cardiac Catheterization Laboratory and named an associate professor of medicine. In 1990, he accepted his current role as director of the Washington Cardiology Center at Georgetown.

A member of the editorial boards of the *American Journal of Cardiology* and the *Journal of the American College of Cardiology*, Dr. Kent is a noted author who has written over 180 articles. He is a Fellow of the American College of Cardiology, the Council on Circulation of the American Heart Association, and the Society for Cardiac Angiography.

Dr. Neal received his medical degree in 1966 from West Virginia University in Morgantown. He completed a rotating internship at Milwaukee County General Hospital in Milwaukee, Wisc., and then served in the U.S. Navy as a flight surgeon for two years.

From 1970-74, Dr. Neal did a residency in pediatrics and a pediatric cardiology fellowship at the University of Minnesota. In 1974, he relocated to Morgantown to become an assistant professor in the Dept. of Pediatrics at WVU. Two years later, Dr. Neal was promoted to an associate professor of pediatrics and was named chief of the Section of Pediatric Cardiology.

In 1981, Dr. Neal was named a full professor at WVU, and in 1985 he was promoted to his current role as professor and chairman of the Dept. of Pediatrics.

Active in numerous national and state committees, Dr. Neal is a member of the board of trustees of the National Association of Children's Hospitals and Related Institutions, a member of the Finance Committee of the Children's Miracle Network, and a member of the Governor's Task Force for Children. He is the author of three books on infant and children's heart disease and has published 60 articles and abstracts.

Dr. Warren was born in New York City and received his medical degree from the University of Rochester School of Medicine in 1969. He finished an internship and residency at the University Hospitals of Cleveland, and then completed a fellowship in cardiology at Duke University Medical Center in Durham, N.C.

After his fellowship, Dr. Warren moved to Charleston to become an assistant clinical professor of medicine at WVU, Charleston Division. He was elevated to associate professor status in 1977, and in 1981 assumed his current post as a clinical professor of medicine. In addition, Dr. Warren has been a clinical professor of medicine at the Marshall University School of Medicine since 1990, and practices with the Charleston Cardiology Group.

A fellow of the American College of Cardiology, Dr. Warren serves on the board of directors of the WV Affiliate of the American Heart Association. He has held a variety of medical staff positions at CAMC including medical director of the CCU and MICU.

A member of the Scientific Advisory Board for Schneider USA, Dr. Warren has developed four catheters for coronary bypass graft angioplasty.

AMA president to deliver address at Annual Meeting

Daniel H. Johnson Jr., M.D., a diagnostic radiologist from Metairie, La., who will become president of the AMA in June, will speak on Saturday morning, August 24 at the beginning of the Second Session of the House of Delegates during the WVSMA's Annual Meeting at The Greenbrier in White Sulphur Springs.

Long active in organized medicine, Dr. Johnson was named president-elect of the AMA in June 1995, had served as speaker of the AMA House of Delegates from 1991-95, and been vice-speaker since 1987. In addition, Dr. Johnson had served as a delegate from 1983 until he became president-elect and as an alternate delegate from 1980-82.

Dr. Johnson chaired the Louisiana State Medical Society's committees on long-range planning, advertising and fee complaints, and alternate delivery systems. He was speaker and vice speaker for the LSMS House of Delegates for 11 years and is a past president of the society.

A founding member of the board of the Louisana Medical Mutual Insurance Company, Dr. Johnson is active on its marketing committee. Dr. Johnson is also a past chair and treasurer of the Louisiana Medical Political Action Committee. Since 1992, he has represented the physicians of Louisana on the Louisiana Healthcare Commission.

Johnson

Born in Port Arthur, Texas, Dr. Johnson received his M.D. degree from the University of Texas at Galveston where he interned in surgery. Following two years of service with the Army, including duty in Vietnam, he trained in diagnostic radiology at Ochsner Foundation Hospital in New Orleans. He is board certified in diagnostic radiology and a Fellow of the American College of Radiology.

In addition to his private practice in Metairie, Dr. Johnson is a clinical professor of radiology and otolaryngology at Tulane University. He also is a past president and past chair of the board of the New Orleans Radiology Society.

WVHA plans Annual Leadership Conference

The West Virginia Hospital Association's Annual Leadership Conference is scheduled for June 19-21 at the Charleston Marriott Hotel.

This year's keynote address will be given by AHA President Dick Davidson. Davidson will present his views of health care in the 21st century and what will be expected in the future by communities.

Also speaking at the conference will be Jamie Orlikoff, a nationally-known health care consultant who will discuss the role of board members and their challenges relative to system integration; Nate Kaufman of the Kaufman Group who will teach participants how to create a hospital-affiliated physician organization, as well as identify strategies for acquiring practices and discuss the financial implications of physician integration and managed care on hospital operations; and Dr. David Plocher, a principal with Ernst & Young, who will provide a perspective on what is achievable in developing integrated systems. In addition, HCCRA Chair Greg Burton will also be making a presentation at the meeting.

For more details, contact Kathy Watts at (304) 344-9744.

Charleston site for WVAAFP's 44th scientific meeting

The 44th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians will this year take place from April 12-14 at the Charleston House Holiday Inn in Charleston, with special preconference events set for Thursday, April 11.

The first preconference activity is a managed care seminar for family physicians and other health care providers which will be conducted from 9 a.m. - 4:15 p.m. The other preconference event, an obstetrical update for family physicians, will then begin with registration and a buffet dinner at 5 p.m. This workshop will feature five guest speakers and is set to conclude at 8:45 p.m.

On Friday, April 12 at 7 a.m., the conference will officially kickoff with registration, a continental breakfast, and the opening of the exhibit hall. The first scientific lecture, *"Issues in Otitis Media: Bacterial Resistance, Clinical Characteristics and Day Care Issues,"* by Itzhak Brook, M.D., of Washington, D.C., is set to begin at 8:30 a.m. after Terry L. Elliott, M.D., president-elect of the WVAAFP who is this year's program chairman, presents an overview of the conference.

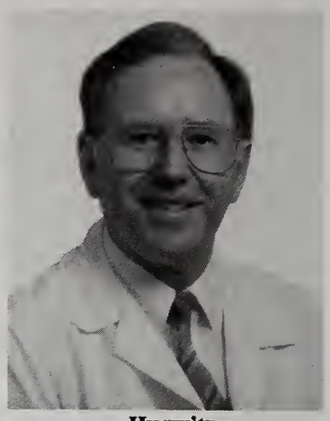
Following Dr. Brook's presentation, Mayor Kemp Melton of Charleston will deliver a welcome to participants and then the meeting will proceed with a lecture entitled *"Estrogen Replacement Therapy: Cardiovascular Implications"* by Philip M. Sarrel, M.D. of Yale. The other lectures that morning will include *"Management of Type II Diabetes in the 1990s"* by Stuart A. Fine, M.D., of Des Plaines, Ill.; and *"Beyond LDL Cholesterol: Adjusting the Focus on Dyslipidemias,"* by Robert Sidney Rosenson, M.D., of Chicago.

At noon, participants will be treated to a luncheon sponsored by Astra Merck in the Exhibit Hall, and a House of Delegates meeting will take place sponsored by SmithKline Beecham.

On Friday afternoon, the scientific sessions will continue at 1:30 p.m. with a lecture entitled *"Hepatitis Update"* by Kevin Mullen, M.D., of Cleveland. The other afternoon sessions will include *"Inflammatory Bowel,"* by Alvin Zfass, M.D., of the Medical College of Virgina; *"H. Pylori Update,"* by Dwayne Smoot, M.D., of Howard University in Washington, D.C.; and *"Gastroesophageal Reflux Update,"* by Jamie Barkin, M.D., of Miami.

Fine

Zfass



Hurwitz

That evening from 6 p.m. - 10 p.m., an alumni party sponsored by Hoechst Marion Roussel, and an all members party hosted by Mylan Pharmaceuticals will take place at the hotel.

On Saturday, the meeting will again offer registration, continental breakfast and exhibit visitation at 7 a.m. A resident directors' breakfast and a complimentary chemistry profile by SVI are also planned before the lectures start at 8 a.m. with *"Women and "Cardiovascular Diseases,"* by G. John DiGregorio, M.D., Ph.D., of Hahnemann Medical College in Pittsburgh. Immediately following, Mitchell Creinin, M.D., will discuss *"The Teen Mom."* The other lectures that morning will be *"Antithromboetic Therapy and Prevention of Strokes,"* by Barrie Hurwitz, M.D. of Duke University Hospital; *"New Advancement in the Treatment of Hypertension,"* by Henry Black, M.D., of Rush Presbyterian St. Luke's Hospital in Chicago; and *"Value of Medicine,"* by George Morrow of Glaxo Wellcome, Inc.

After a variety of luncheon events, the meeting will reconvene at 1:30 p.m. with the lecture, *"Treatment of Outpatient COPD and Pneumonia,"* by Michael Niederman, M.D., of Winthrop University Hospital in Mineola, N.Y. Three more presentations will take place that afternoon: *"Family Practitioners' Guide to Treatment of Hypertension and Angina,"* by Gary Gerstenblith, M.D.; *"Appropriate Use of Antihistamines,"* by Brian Wispelway, M.D., of the University of Virginia in Charlottsville; and *"The Focus on the Patient: Psychological Aspects of Epilepsy Therapy,"* by Carl McComas, M.D., of Huntington.

At 6:30 p.m. Saturday evening, a reception will be sponsored by Bristol Myers Squibb, and then the annual banquet and installation of officers will be presented followed by an dessert party sponsored by Eli Lilly & Company.

The meeting will then conclude at noon on Sunday after four lectures and drawings for door prizes for exhibitors and physicians. Sunday's sessions will feature Jerome Z. Litt, M.D. of Pepper Pike, Ohio, discussing *"Making Rash Decisions;"* Richard G. Fried, M.D., Ph.D., of Yardley, Pa., talking about *"Treatment Options for Common but Difficult Dermatoses;"* Jules Rosen, M.D., speaking on *"Masked Depression in the Elderly: The Exclusive Presentation;"* and Gregory K. Bergey, M.D., discussing *"Treatment of Partial and Generalized Onset Epilepsy."*

This program has been reviewed and is acceptable for 19.75 prescribed hours by the AAFP. AAFP prescribed credit is accepted by the AMA as equivalent to the AMA PRA Category 1. AOA individual certificate forms with 19.75 AOA Category 2-A credit will be available at the registration desk.

For more details, phone 776-1178.

KEEPING RURAL HEALTHY:
A COMMUNITY CHALLENGE
19th Annual National Conference
National Rural Health Association
May 15 - 18, 1996
Minneapolis, Minnesota

Medical Assurance offering onsite risk management education

To supplement its statewide loss prevention seminars, Medical Assurance of West Virginia, Inc., has tailored two new onsite risk managements programs, *"Keys to a Successful Medical Office,"* which is designed for office personnel, and *"Medical Malpractice: Reducing Your Risk,"* which focuses on physicians.

The following is a brief description of each program:

Keys to a Successful Medical Office

Physicians can be involved in medical malpractice lawsuits that are not prompted by actual medical negligence, but by deficiencies in their medical office systems, communications and documentation practices. This seminar was designed by Medical Assurance for physicians' office staffs to increase awareness of liability issues in the office setting. Understanding malpractice vulnerabilities is the key to prevention. During the seminar, factors which commonly lead to a medical malpractice lawsuit are explained, as well as the importance of communications as they relate to patient and staff interactions, telephone communications, angry patients and confidentiality issues. The office procedures and systems as they relate to scheduling, cancelled and missed appointments, diagnostic follow-up, release of medical records and X-rays are discussed. The role of the medical record in a malpractice lawsuit is also stressed and specifics are identified that must be documented. Remember, jurors believe that sloppy records imply sloppy care and if it is not charted in the medical record, it NEVER happened!

This two-hour seminar is free and can be scheduled for large multi-physician practices or a combination of several solo (or small group practices).

Medical Malpractice: Reducing Your Risk

Despite the impact malpractice litigation has on physicians personally and professionally, many doctors do not protect themselves by learning loss prevention strategies and taking measures to avoid the leading causes of malpractice claims. This seminar defines malpractice and the elements of negligence, reviews factors that trigger a malpractice lawsuit, and identifies risk management techniques and strategies for minimizing physician involvement in a malpractice lawsuit. It discusses the three Rs of risk control: records, rapport and reason. Good medical documentation is the physician's best defense in the event of a malpractice claim. Since the health and wellbeing of patients depends on a collaborative effort between the physician and patient, the physician-patient relationship is of greatest benefit to patients when they bring medical problems to the attention of their physician in a timely manner and work with him/her in a mutually respectful alliance. Many malpractice claims and lawsuits are traced to patients' erroneous belief than an adverse outcome is proof of negligent treatment and inadequate care. These beliefs occur when physicians have not taken time to adequately explain the nature, scope, limitations, risks and complications of proposed treatment or surgery. Patients have unrealistic expectations about what physicians can and cannot do. Therefore, patient rapport and communication is key to loss prevention.

This two and a half hour presentation is free and can be prepared for hospital medical staffs, county component societies, and specialty societies.

For more information about these presentations, contact Kathi Burton, Medical Assurance's senior risk management specialist, at 522-0601 or 1-800-331-6298.

Medical Assurance

Journal article on Medicaid program earns high praise

Dr. F. Thomas Sporck, M.D., F.A.C.S., chairman of the WVSMA's Legislative Committee who recently served on Governor Caperton's Medicaid Crisis Panel, has stated he has received numerous favorable comments about the article entitled *"An overview of the Medicaid program in West Virginia,"* which appeared in the January/February issue of the *West Virginia Medical Journal.*

"Several members of the Medicaid Crisis Panel, as well as legislators and WVSMA members have told me that this article was one of the best they have ever read about the Medicaid program in West Virginia," Dr. Sporck said. "In fact, many of them have told me they have kept this issue for future reference because it provides such a wealth of useful information. Winnie Morano, the WVSMA's director of government relations, is to be commended for the outstanding job she did of compiling this article."

Ophthalmologists to hold 49th meeting

The West Virginia Academy of Ophthalmology's 49th Annual National Spring Meeting will take place from April 25-28 at The Greenbrier in White Sulphur Springs.

Featured speakers include Eve Higgenbotham, M.D., who will lecture on glaucoma; Walter Stark, M.D., who will discuss cataracts and the cornea; Herve Byron, M.D., who will talk about business/practice management, managed care and medico-legal topics, and Curtis Margo, M.D., who will lecture on practical ophthalmic pathology.

This CME event has been designated by the WV Academy of Ophthalmology for 12 credit hours of Category 1 for the AMA's PRA.

For further information, contact Pam Stevens, WV Academy of Ophthalmology, P.O. Box 5008, Charleston, WV 25361, (304) 343-5842 or fax (304) 344-3130.

SEATBELTS
Everybody's Wearing Them

Continuing Medical Education

Listed on this page are some of the upcoming CME programs for physicians which will be held in the state and region. Unless otherwise noted, these events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization printed in the *Journal*, contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

March 21
(Teleconference) "Diagnostic Angioplasty," Joseph Skeens, M.D.

March 29
"23rd Annual Newborn Day"

April 1
"Respiratory Care Seminar"

April 10
"Working Effectively with Difficult or Challenging Learners"

April 11
"Obstetrical Update: A Pre-Conference for the Family Physician"

April 18
"Let's Talk Health - Mitral Valve Prolapse: Signs and Symptoms"

April 20
"Diagnosis and Treatment of Knee/Ankle Injuries in the Competitive Athlete"

April 20
"Four State Neuroscience Conference"

Marshall University School of Medicine - Huntington

March 20
"Ob/Gyn Grand Rounds: Androgens and Women's Health," Ramona Sluplik, M.D., Cabell Huntington Hospital, 7 a.m.

March 21
"Osteoporosis," Howard Feinberg, D.O., Cabell Huntington Hospital, noon

March 25
"Diagnosis and Management of CLL and Related Disorders," James Bennett, M.D., Radisson Hotel, 6 p.m.

March 26
"Diagnosis and Management of Myelodysplastic Syndrome," James Bennett, M.D., St. Mary's Hospital, 8 a.m.

March 28
"Women and Mood Disorders," Stephen Pariser, M.D., Cabell Huntington Hospital, noon

April 20
"Heiner Lecture: Hormone Replacement Therapy," Julia Donovan, M.D., Fine Arts Building

April 22
"Head and Neck Carcinoma," Frank Dunphy, M.D., St. Mary's Hospital, 8 a.m.

May 3
"Depression with Sleep Disorder," Andrew Winokur, M.D., Erikson Alumni Center, noon

Huntington Medical Community Foundation - Huntington

March 21
"New Concepts in Cerebral Palsy," Thomas A. Rugino, M.D., St. Joseph's Hospital, Parkersburg, 7:10 a.m.

April 4
"Infections in the Elderly," Thomas Rushton, M.D., Putnam General Hospital, Hurricane, 12:15 p.m.

April 8
"Treatment of Seizure Disorders," Carl F. McComas, M.D., Three Rivers Medical Center, Louisa, Ky., 6 p.m.

April 10
"TBA," Thomas A. Rugino, M.D., Tug Valley Medical Society, Williamson, 6:30 p.m.

April 16
"Signs and Symptoms of Abuse for Health Care Workers," Julie Rice Brewer, C.N.M., Logan General Hospital, Logan, noon

April 18
"TBA," St. Joseph's Hospital, Parkersburg, 7:10 a.m.

April 18
"Diarrheal Diseases: A Practical Review," Charles E. Turner, M.D., Mason County Medical Society, Point Pleasant, 6 p.m.

April 30
"TBA," Paul B. Hall Regional Medical Center, Paintsville, Ky., 7 p.m.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

March 28-29
"Spirometry Certification Training"

April 13
"11th Medicolegal Investigation of Death Seminar"

April 18
"Fourth Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine"

April 18
"John E. Jones, M.D. Symposium on Health Policy"

April 27
"Third Annual Issues in Cancer Care Conference"

Outreach Programs

Fairmont ★ Fairmont Clinic, March 20, 1 p.m., "Acute Renal Failure," Dianne Muchant, M.D.

★ Fairmont General Hospital, April 2, 7:30 p.m., "Parenting the 13-15 Year Old," Kathaleen Perkins, M.D.

★ Fairmont Clinic, April 17, 1 p.m., "Workers Comp WV Statute: M.D. Obligations and Common Practice," Edward Doyle, M.D.

Hill Top ☐ Hill Top Nursing Home, March 26, 6 p.m. "Psychotrophic Drugs," Anita Lorenzo, Pharm.D.

Man ☐ Man Appalachian Regional Hospital, March 20, 6 p.m., "Cardiac Arrest in Children," Manual Caceres, M.D.

New Martinsville ★ Wetzel County Hospital, April 11, 6:30 p.m., "Cancer Pain Management," David Smith, M.D. and Diedre Rockey, M.S.N.

Parkersburg ★ Camden-Clark Mem. Hospital, April 10, 7:30 a.m., "Improving Perinatal Outcomes," Leo Brancazio, M.D.

Philippi ★ Broaddus Hospital, April 11, 1 p.m., "Alzheimer's Disease," Robert Keefover, M.D.

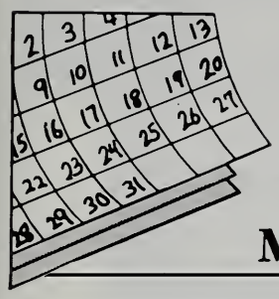
Point Pleasant ☐ Pleasant Valley Hospital, March 28, noon, "Diabetic Management," Greta Flanagan, M.D.

Ripley ☐ McCoy's Best Western, March 27, 6 p.m., "Treatment of COPD and Asthma," Juan D'Brot, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, March 25, 4 p.m., "Nutrition and Heart Disease," Robert Hoeldtke, M.D.

★ The Greenbrier Clinic, April 22, 4 p.m. "Health Concerns in International Travel," Gregory Juckett, M.D.

★ *Robert C. Byrd HSC of WVU*
☐ *Charleston Area Medical Center*



Medical Meetings

April

14-17–American College of Surgeons, New York City

15-17–American Society for Laser Medicine and Surgery, Inc., Orlando

17-19–Clinical Cardiology Management and Diagnostic Dilemmas, Santa Fe

19-20–Clinical Innovations in OB/GYN Ultrasound (sponsored by Columbia University College of Physicians and Surgeons), New York City

20-25–College of American Pathologists and the American Society of Clinical Pathologists, Boston

22–Network Accreditation, Risk Management, and the Physician Office Site, Washington, D.C.

25-28–American College of Physicians, San Francisco

25-28–MRI Neuro Weekend Review (sponsored by MRI Education, Inc.), Cincinnati

25-28–West Virginia Academy of Ophthalmology's 49th Annual National Spring Meeting, White Sulphur Springs

26-27–Annual Meeting of the Virginia Society of Otolaryngology, Hot Springs, Va.

26-28–Ethical Issues in Renal Dialysis and Kidney Transplantation (sponsored by CEREC of Southeast Florida), Ft. Lauderdale

28-May 1–American Association for Thoracic Surgery, San Diego

28-May 2–American College of Obstetricians and Gynecologists, Denver

26-May 3–American College of Occupational and Environmental Medicine, San Antonio

May

4-9–American Psychiatric Association's 149th Annual Meeting, New York City

5-6–Medical Practice Solutions in an Electronic Era (sponsored by the AMA), San Antonio

5-8–Congenital Heart Disease in the Adult (sponsored by the American College of Cardiology), Stevenson, Wash.

8-10–Clinical Auscultation of the Heart (sponsored by the American College of Cardiology), Washington, D.C.

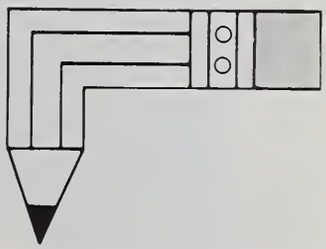
11-19–Toward an Electronic Patient Record '96 Conference and Exposition (sponsored by Medical Records Institute), San Diego

15-18–19th Annual National Conference of the National Rural Health Association, Minneapolis

16-19–Clinical Magnetic Resonance Society's Annual Meeting, Disney World/ Epcot Center, Florida.

For More Information...
Contact the Journal at (304) 925-0342

Poetry Corner



The Classroom

I sit quietly in the classroom
Soon to be filled with active minds
But in this early morning hour it is peaceful
Probably the only rest it finds

I wonder about the throngs who have learned here
Have they gone on to greater heights?
Does this room echo their greatness?
Have they soared like wind-blown kites?

Or have they faced losses and despair
As they struggled to succeed?
And who was there to love and help
In their minutes and hours of need?

I can almost hear their voices
In the silence of the room
And in the flitting shadows
Their darting faces loom

But here there is no anguish
Only murmurs of excitement and hope
This quiet classroom is a peaceful spot
The future is its scope

David Z. Morgan, M.D.

Wintering

Look yonder!
A lonesome hill covered in trees the color of dried roses
Splashed with warming sun.
Resting beneath are the last green meadows with the tracks of deer basking in sunlight.

Rolling roads,
Slices of concrete and steel bands carving out the meadows and hills of the wild turkeys.
Rocks reflected
In the stream at the bridge across cold blue and purple shady hillsides traced with frost and icy fractures.

Hear the song
That hushed mountains, skies, and men when Indians hunted here, that rolled over the land when wagons came.
Now fenced,
Snow fields sticking on roads like melted marshmallows
Beneath a smoke-gray and fiery sky.

Lee L. Neilan, M.D.

Department of Health & Human Resources
Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

A Day in the Life of Public Health

The sun wakes you as it peaks over the mountain ridge and you smell the coffee brewing from the kitchen. Last night, as you set the timer and filled the pot, you took for granted that the water coming from the faucet was safe to drink, just as you do this morning as you brush your teeth. However, you recall your dentist telling you at your last check-up that, while it's good to use fluoridated toothpaste, your family also benefits from the fluoride treatment in your local water supply.

You hear your daughter reminding your wife to sign a permission slip because this is the week the local health nurses will be coming into her school. They'll be giving her and all the 6th graders a second dose MMR shot to protect them against measles, mumps and rubella. That reminds you of the call from your sister last night. She has an appointment to take her baby in for his latest round of immunizations that ward off diseases that used to be deadly in the "olden days." The best part is she won't have to spend all day driving to the city because the public health folks realized the need for doctors in her rural community and helped to place one there.

As you drink your coffee you're proud to see your son's picture on the front page of the morning newspaper's community section. He and several of his classmates have won an award for designing a campaign to discourage students from using drugs and alcohol. You smile at him across the table as he drinks a glass of milk - - milk you know is safe because public health employees inspect the dairies, conduct lab tests of milk samples and check refrigeration levels in food stores.

It's time to leave for work and before you even start the car you buckle your seatbelt. It's always been a habit for your family and you're glad that it's now the state law, thanks to public health education studies that show using seatbelts greatly reduces motor vehicle accident-related deaths.

On the way to the office you stop by your favorite fast food restaurant for a biscuit. You feel good about the way the food was prepared because the local health department sanitarians awarded 95 out of 100 possible points to the restaurant during their last inspection, ensuring that proper standards have been met. But then another public health message comes to mind when you realize you would have been better off to have a healthier, low-fat breakfast because you know your cholesterol level is too high.

Public Health Week

April 1-7, 1996

Work is good, but you look forward to noon. Company managers realize worksite wellness makes good business sense, so they encourage activities like the lunchtime walking program you and several of your co-workers have started. It's even easier these days because the new community walking trail is just across from your office building. You like exercise because you know it increases your aerobic fitness and helps your stress level for the rest of the afternoon. You've also read about public health studies that show the positive effects of regular exercise to avoid or lessen the risks of chronic disease and stress.

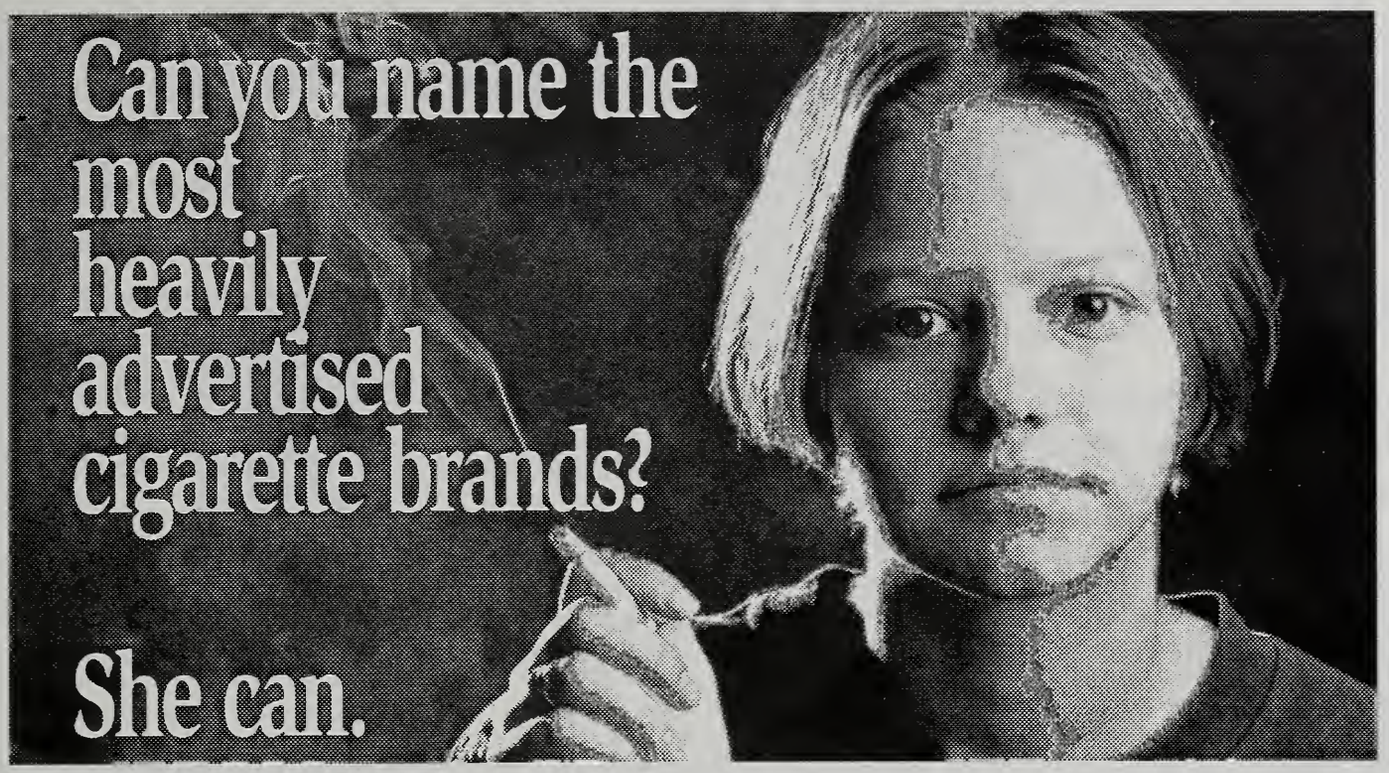
As you reenter the building, you notice how nice it is to work in a smoke-free environment. In fact, you and your wife will be speaking at a public hearing next week in support of the local board of health's plan to pass a county-wide clean indoor air regulation to protect the public from the hazards of secondhand smoke.

On the way home you stop by the personal care home to visit your mother. Since your father died it has been hard to see her slow down to the point where she could no longer live alone, but you've seen how much happier she is now that she moved here. She really enjoys the chance to interact with people her own age and the staff treat her like family. You feel confident about this facility because it has always rated high in public health licensing surveys.

After dinner, you relax with your family and watch the local news. There's a report on a local injury prevention project where a local public health official describes the positive outcomes in the community that have resulted, and he explains some measures for injury prevention that can be taken at home. Your daughter proudly reminds you that she already knows how important it is to always wear a helmet when she rides her bike.

As your family goes to sleep, the moon glows high over the valley. Musing about the day's activities and all the days ahead, you realize that the emphasis on public health isn't a one-day or week-long event, but an everyday concept we can adopt and be better able to celebrate by living healthy.

Public Health Week is April 1-7. To obtain more details about how public health affects you and your family, phone the West Virginia Bureau for Public Health at (304) 558-2971 or call your local health department.



Eighty-five percent of children who smoke prefer the three most advertised brands (Marlboro, Camel and Newport). That's no coincidence.

Tobacco companies spend billions on cartoon ads, billboards near schools and mountains of free merchandise that kids love (T-shirts, caps, backpacks, jackets). The results:

- ***Three thousand kids start smoking every day.***
- ***Nearly all adult smokers begin as children.***
- ***One-third will die from their addiction.***
- ***Tobacco companies are making $200 million a year from sales to children and addicting a new generation of customers.***

The nation's top health experts have proposed new limits to keep tobacco marketing from seducing children and to make cigarettes less accessible to kids. But industry lobbyists are scheming to snuff these rules out.

It's time we stopped trusting tobacco companies with our children's lives.

- ***Tell the FDA you support the proposed limits*** *(Food & Drug Administration, Docket 95N-0253, Room 1-23, 12420 Parklawn Drive, Rockville, MD 20857).*
- ***Tell your Members of Congress not to endanger America's children for tobacco company profits.***
- ***Learn more by calling 1-800-284-KIDS.***

This ad sponsored by the National PTA, American Nurses Association, National Association of Secondary School Principals, National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) and over 100 other organizations throughout the country.

CAMPAIGN for TOBACCO-FREE Kids

The Coalition on Smoking or Health will observe March 20 as a lobby day in Washington, D.C. to support the proposed FDA changes.

ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

High success rate achieved by coronary bypass program

Murray

New data on operative mortality associated with coronary artery bypass procedures reflect well on WVU's surgery program. The National Cardiac Surgery Database of the Society of Thoracic Surgeons reported a national mortality rate of 3.2% in 1994-95, and WVU data show a 1995 mortality rate of just 2.2%.

"We've worked hard to reach this level," said Dr. Gordon Murray, chair of WVU's Department of Surgery. "These figures reflect not only the excellence of our surgeons, but also the high quality of our nurses and support teams who work with patients before and after surgery."

WVU surgeons perform bypass procedures at both Ruby Memorial Hospital and at Monongalia General Hospital.

Breast Care Center performs new biopsy

WVU's Betty Puskar Breast Care Center is now giving women who need breast biopsies the option of a new non-surgical procedure called a percutaneous large core breast biopsy.

This procedure involves removing small pieces of tissue from the breast. Computer-enhanced mammographic images are used to guide the biopsy device to the abnormal area.

"The biopsy has an extremely low complication rate and provides accurate diagnosis of the lesion, with minimal invasion," says Dr. Judith Schreiman, director of the center. "The cosmetic results are excellent."

Percutaneous large core breast biopsies can be performed with patients in an upright or horizontal position, depending on the type of equipment used.

"We use a prone table, which means the patient lies flat on her stomach," says Dr. Schreiman. "By doing it this way, the patient is more comfortable and doesn't have to see the procedure being performed."

The Betty Puskar Breast Care Center opened in December and is part of the Mary Babb Randolph Cancer Center. The center provides every available service related to breast care and is accredited by the American College of Radiology. It is federally certified by the FDA under the Mammography Quality Standards Act to provide quality breast imaging.

PET center now available for patients

The Positron Emission Tomography (PET) center at WVU, which allows physicians to observe the functioning of organs and systems in the body, is now open for patients.

The $10 million facility is part of the Center for Advanced Imaging and it has been open for research studies since October. The center is expected to greatly advance the ability of physicians to diagnose cancer, neurological and heart diseases, and other serious illnesses.

West Virginia's Health Care Cost Review Authority (HCCRA) granted the Health Sciences Center permission in January for the PET Center to begin performing tests for patients referred by physicians. In a PET test, patients are injected with small quantities of radioactive tracer material. This tracer is carried in the bloodstream to the organ the doctor wants to study.

The scanner detects positrons emitted by the tracer and can record chemical activity and other data about the organ. A computer then analyzes the data and produces a live color picture of the organ. The radioactive materials used break down very quickly after the test and cause no harmful side effects, said Dr. Naresh Gupta, director of the PET Center.

UHA names new CEO

Wright

W. Robert Wright Jr., has been named president and chief executive officer of University Health Associates (UHA), which manages the medical and dental practices for WVU's Schools of Medcine and Dentistry.

Wright, who started his new post on March 11, served as the COO for the medical practice plan at the University of Virginia Health Services Foundation since 1991. While at the University of Virginia, he helped the institution form a for-profit managed care company licensed as an HMO, and served as its interim vice president.

Guide to clinical services published

The more than 25 new clinical services at the Robert C. Byrd HSC are described in a new guide.

Some of the new clinics featured in the booklet are the laser clinic, the multidisciplinary lung cancer clinic, the dizziness clinic, and the sports injury clinic. Also discussed in the guide are high-dose-rate brachytherapy, collagen implant for stress incontinence, cryotherapy in surgery of the liver, and much more.

To receive a guide, call 1-800-982-6277.

MDTV adds new sites

Mountaineer Doctor Television (MDTV) is expanding to include sites at Roane General Hospital, the West Virginia Osteopathic School of Medicine, Cabell-Huntington Hospital, which shares a site with Marshall University, Rainelle Medical Center, and Monroe Health Center in Union.

There are now a total of 15 MDTV sites in the state. MDTV is a two-way audio and video network that allows health professionals nearly instant access to the medical, technological, and educational resources at the HSC.

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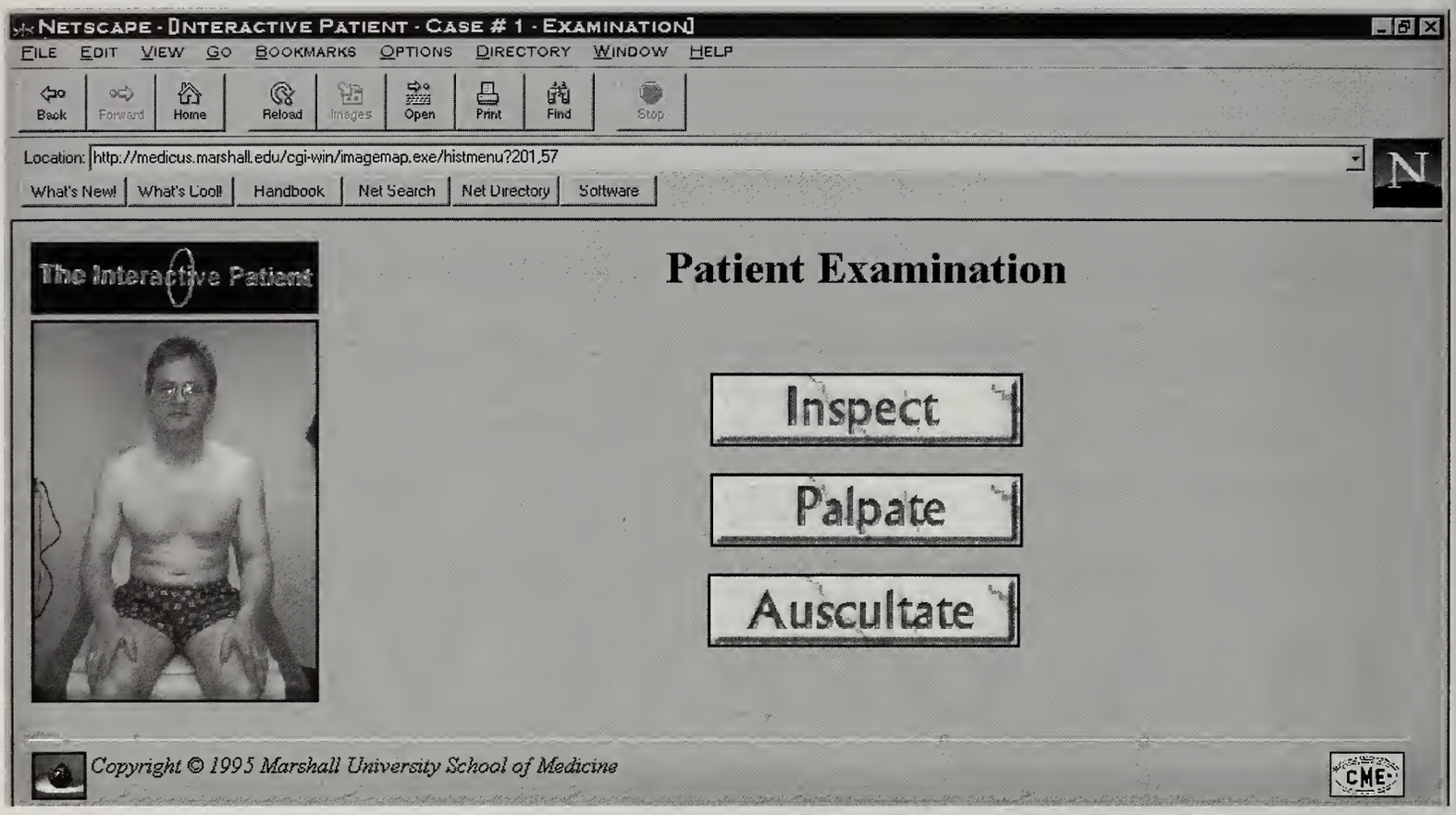
Lodging accommodations vary from deluxe condominiums to affordable lodge rooms with prices to meet any budget. This year, don't *overlook* Snowshoe Mountain Resort. Give us the opportunity to tell you more about what we have to offer.

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

MU's unique Internet program in great demand



Since June, more than a quarter of a million people have "visited" the School of Medicine via Marshall's one-of-a-kind CME program on the Internet called Interactive Patient.

The World Health Organization has provided links to Interactive Patient, and news media from as far away as London and Melbourne have written about it. In addition, this unique program has received the Exceptional Resource Award of the Multimedia Medical Reference Library, and its developers, Kent Hayes and Christoph Lehmann, have had an article on the project accepted by the peer-reviewed journal M.D. Computing.

"We never would have believed the amount of interest this has generated," said Hayes, director of administrative computing at MU. "We've gotten calls from all over the world, and have even had requests from universities overseas to mirror the site. Right after InfiNet named Interactive Patient a 'Cool Site of the Day,' we were getting more than 40,000 'hits' a day. I thought we were going to need a fire extinguisher to cool off the hard drive!"

The program simulates a patient encounter, giving physicians a chance to sharpen their clinical and history-taking skills. Users ask questions of the patient, who is prepared with about 1,700 possible responses. Lehmann, who developed the clinical case, said he deliberately made the history-taking process challenging.

"Special emphasis was placed on making the Interactive Patient's answers as realistic as possible," Lehmann said. "Information is not volunteered easily, and, like a regular patient, this program understands only limited medical terminology, so it requires exact questioning in 'layperson' terms to get answers leading to the diagnosis."

MU created this program as a way to provide a CME opportunity for rural physicians who find it difficult to leave their practices for conferences.

To access the Interactive Patient (http://medicus.marshall.edu/), users need to have a computer with a sound card, Internet access and a World Wide Web browser.

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Alliance News

Ready for spring!

I want to personally invite all the WVSMA Alliance members to attend our Spring Board Meeting which will be conducted at the WVSMA office in Charleston on Tuesday, April 16. This meeting will provide you with the opportunity to see what is available to you as a member in the Alliance, discuss your ideas openly and learn from what other members throughout the state have to say. WVSMAA President-Elect Amy Ricard will be presenting us with a preview for the upcoming year and the state officers, state chairs, county presidents and and county president-elects will be voting on a number of issues. We want to thank the Kanawha County Medical Society Alliance for hosting this meeting and send our special thanks to Debbie Lane and Bonnie Fidler for all their efforts. Hope to see you there!

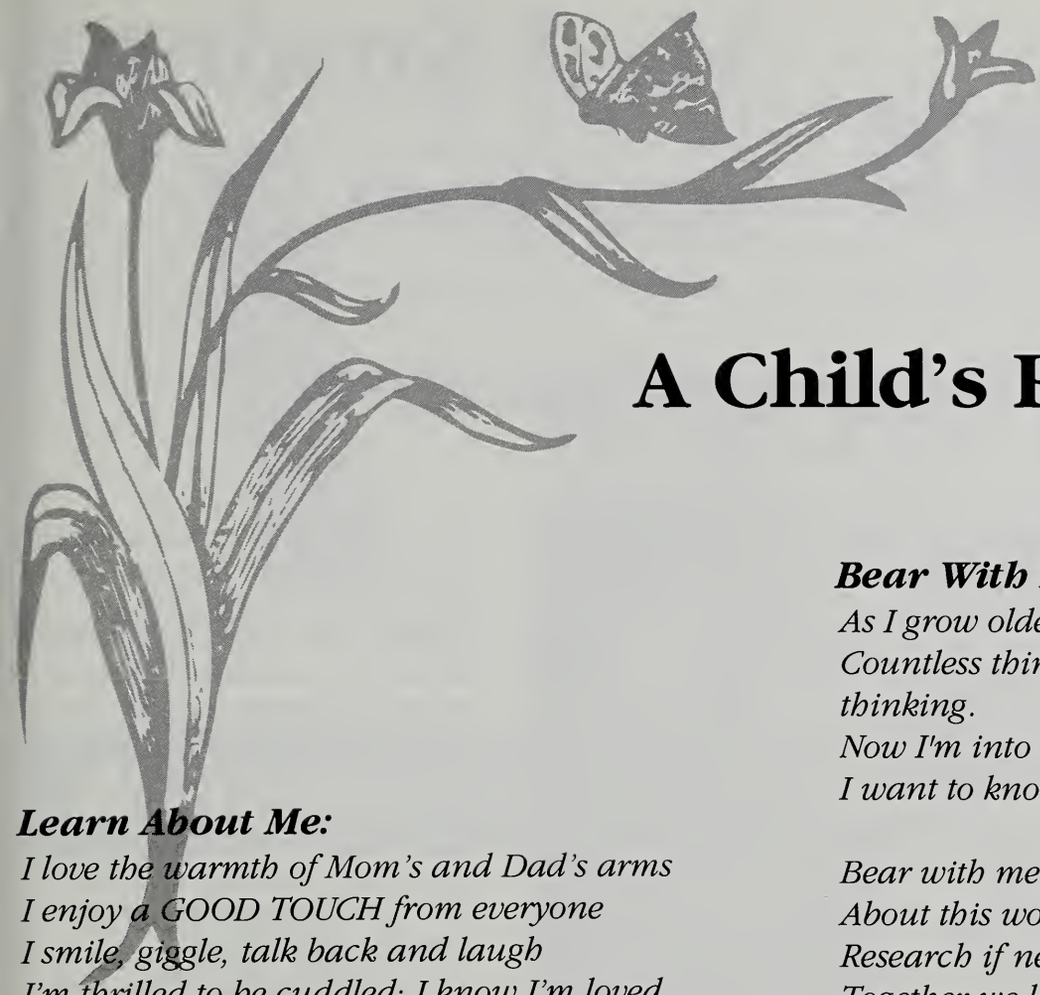
In other Alliance news, the West Virginia State Board of Education has approved the materials which we plan on distributing to all schools this year for our state health project. We think this curriculum will be an excellent way to help adolescents. For your copy of this material, please contact Louann Fagundo at (304) 243-1494 or write her at 23 Lynwood Avenue, Wheeling, WV 26003.

With the primary election fast approaching, I want to urge all county alliances to have a voter's registration as soon as possible. In addition, please take time to read over the article that begins on on page 62 which provides the results of the gubernatorial questionnaire and biographical materials on some of the candidates for Supreme Court. This article was compiled by the Alliance's Executive Secetary Winnie Morano, who is also the WVSMA's director of government relations. In addition, it is critical for you and your spouse to read the editorial on page 96.

What great ideas come from brainstorming!!! I was working at the WVSMA office recently with Amy Ricard, Sue Bryant and Ruth Gilbert and we came up with the idea of having an art sale at the Alliance's Annual Meeting in August to raise money for AMA-ERF, which provides educational funds for medical students. For this art sale, we would like anyone associated with the WVSMA or WVSMAA to donate personal paintings, sculpture, pottery, photographs, drawings, needlepoint, etc.. A silent auction will be held to sell these items and donations would be tax deductible. Anyone wishing to donate may contact Janie Altmeyer, convention chair, at 242-8447.

In closing, I want to commend the WVSMA for the outstanding Lunch and Learn program on domestic violence which was presented at the WVSMA's 1996 Mid-Winter Seminars and Scientific Conferences in January. In order to further educate individuals about this subject, I am very pleased to offer readers a very touching poem entitled *"A Child's Plea to Society"* which was written by Lucy Blando of the Raleigh County Medical Society Alliance. Lucy was inspired to write this poem by the WVSMAA's involvement with SAVE (Stop America's Violence Everywhere) Day, which was created by the AMAA and celebrated on October 11.

Linda Elliott
WVSMAA President



A Child's Plea to Society

Learn About Me:

I love the warmth of Mom's and Dad's arms
I enjoy a GOOD TOUCH from everyone
I smile, giggle, talk back and laugh
I'm thrilled to be cuddled; I know I'm loved.

I listen to the lullabies Mom and Dad sing to me,
I feel their soft hands as I'm tucked into bed nightly.
When I'm sick I see them watching me patiently,
All of these mean BONDING of family.

I sense when my family is happy or sad
I know between good and bad touch
I learn of wars, violence, conflicts among us
These all become a part of my life.

Read to Me:

I like wildlife stories and a little comedy,
Classics, history and mysteries challenge me.
Action songs and dancing get me going,
Spending time together is
RELATIONSHIP BUILDING.
You may treat me to a little TV
But be sure the show is good for me.

Bear With Me:

As I grow older I find the world so amusing
Countless things and events way beyond my thinking.
Now I'm into exploring and discovering
I want to know about everything.

Bear with me as I begin questioning
About this world so intriguing.
Research if needed, I want honest answers
Together we learn, knowledge we'll keep forever.

Educate Me:

On how to make healthy choices from bad
On how to stand up for what's right without being mocked,
On how to say NO when pressured by pals
On how to face conflicts, emergencies as they arise.

Finally:

After you have answered my plea,
You shall have done your part as a society.
You certainly make a difference in me,
The world can now live in peace and harmony.

By Lucy Blando, President
Raleigh County Medical Society Alliance

Med Student Section

Annual Meeting Highlights

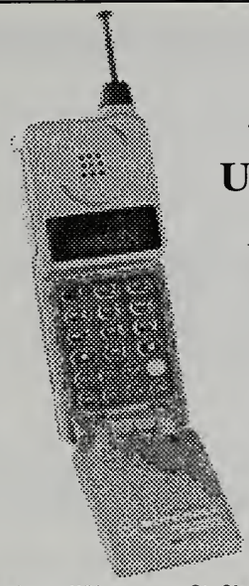
The 1995-96 officers and members of the WVSMA Medical Student Section attending the annual meeting on January 20 included:

(Front Row) Dominic J. Cottrell, president; Melissa Matulis, vice president; and Kristen DeHaven, secretary-treasurer.

(Second Row) Constance L. Anderson; Melinda Wang; Bonnie Bailey; Amy Horsman Shamblin; Mary Rose Boehm; and David Faber, past president.

(Third row) Rodney Dayo; Beth Jenkins; Staci Jones; Jason Ridgel; and Mary Jo Martin.

Senator Jay Rockefeller greets medical students, Dave Faber, Anne Glover and Kristen DeHaven at the conclusion of the Physician/Public Session, which was held during the WVSMA's Mid-Winter Seminars and Scientific Conferences on Friday evening, January 19.



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New Members

We would like to welcome the following physicians to the WVSMA:

Physicians

Abdullah Al-Mahayri, MD
Jackson, WV

Abbas Y. Elkhatib, MD
Beckley, WV

Richard Patterson, MD
Huntington, WV

Thomas Von Dohlen, MD
Lewisburg, WV

Rebecca A. Price, MD
Morgantown, WV

Paul R. Capito, MD
Huntington, WV

Mark Newfeld, MD
Huntington, WV

Jeffery A. Adams, MD
Bluefield, WV

Patrick C. Bonasso, MD
Fairmont, WV

Ian T. Legget, MD
Fairmont, WV

Debra K. McKenzie, MD
Fairmont, WV

Rabas Boukehemis, MD
Huntington, WV

Janet M. Cochran, MD
Charleston, WV

Richard E. Cain, MD
Parkersburg, WV

Harold J Wallace, III, MD
Wheeling, WV

Catherine J. Evans, MD
Wheeling, WV

B. Thanasophon, MD
Williamson, WV

Noel Ashcraft, MD
Morgantown, WV

Mohammad A. Khan, MD
Romney, WV

William A. Stewart, MD
Charleston, WV

Antoine Katiny, MD
Sutton, WV

Brandt Williamson, MD
Martinsburg, WV

Daryl LaRusso, MD
Martinsburg, WV

John C. Veltman, MD
Martinsburg, WV

John W. Ellis, MD
Martinsburg, WV

Gene B. Duremdes, MD
Princeton, WV

Deborah J. Hiltz, MD
Fairmont, WV

Maan Younes, MD
Williamson, WV

Eric B. Ingersoll, MD
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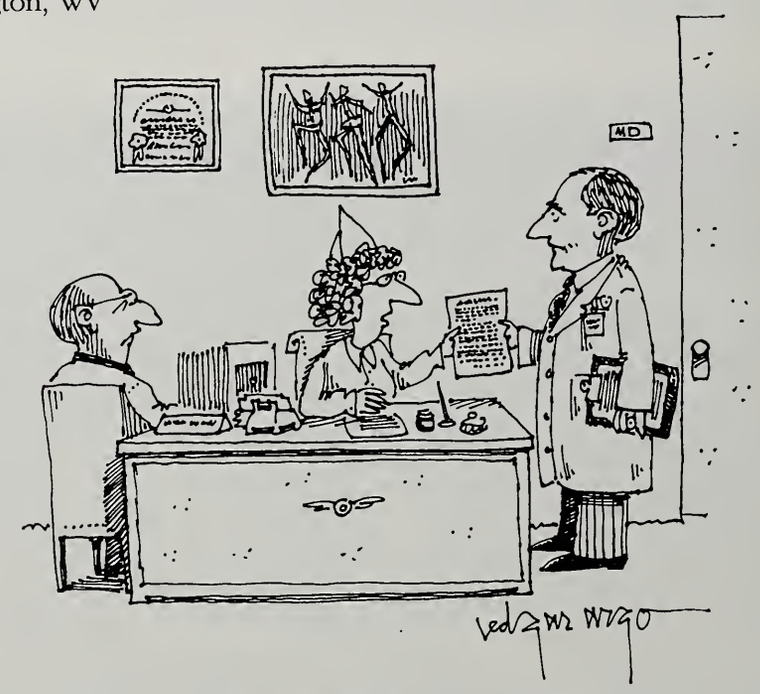

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Contributions for WESPAC/AMPAC are not deductible as charitable contributions for federal income tax purposes. A portion of your WESPAC contribution is sent to AMPAC thus enrolling you as an AMPAC member as well.

Obituaries

Otis E. Linkous Jr., M.D.

Dr. Otis E. Linkous Jr., 78, of Welch, died December 26 at Welch Emergency Hospital.

Born in War, Dr. Linkous was the son of the late Otis E. and Ida Christian Linkous Sr. He had been a resident of Welch most of his life, and he was a graduate of Virginia Polytechnic Institute and the Medical College of Virginia.

A veteran of the U.S. Army, Dr. Linkous served during World War II in the Medical Corps. After his military service, he had practiced medicine in McDowell County since 1945 until his retirement in 1986. He was a member of the First United Methodist Church in Welch.

Dr. Linkous is survived by his wife, Mrs. Conner Hall Linkous; one son, Otis E. Linkous III of Springfield, Va.; two daughters, Mrs. W. Harrison (Marsha L.) Turner III of Greensboro, N.C., and Mrs. Richard W. (Nancy L.) Hatfield of Lexington, Ky.; one brother, Howard Wise Linkous of Welch; two grandsons, Matthew Hatfield of Lexington, Ky., and Otis E. Linkous IV of Springfield, Va.; and three granddaughters, Mrs. James (Katherine) Hardy and Laura M. Linkous, both of Springfield, Va., and Jane S. Hatfield of Lexington, Ky.

Contributions may be made to the First United Methodist Church, P.O. Box 416, Welch, W.Va., 24801.

Deanna L. Myers

Deanna L. Sefton Myers, 35, of Sissonville, who worked closely with the WVSMA staff and members in her role with the Medicare Division of Nationwide Insurance Co., died January 24 at CAMC, Memorial Division, after a long illness. Deanna was a member of Sissonville Church of Christ and a lifelong resident of Sissonville.

Surviving are her husband, Jamie Myers; sons, Eric James and Nicholas Lee, both at home; parents, James D. and Lois Sefton of Sissonville; sisters, Sharon Sefton and Lisa Thomas, both of Sissonville, and Shellie Vannatta of Ohio; brother, David Sefton of Sissonville; paternal grandmother, Bessie Sefton of West Logan.

Chester L. Shanklin

Chester L. Shanklin, 78, husband of WVSMA Finance Manager Sue Shanklin, died February 6, in CAMC, Memorial Division, after a long illness due to cancer.

Chester was a native of Kanawha County. He was a retired director and supervisor for the state Department of Tax with 27 years of service, a former Senate aide in the state Legislature with six years of service and a former accountant and office manager for Wyatt Coal Co. with 18 years of service. Chester was a 25-year member of Oakwood Baptist Church where he was a member of the church choir, served as Sunday school superintendent, was president of the Men's Fellowship and was chairman of the trustee and nominating committees.

An Army veteran of WWII, Chester was a past commander and quartermaster of VFW Post 3466 and served as state chairman of the VFW voice of the Democracy Scholarship program. He was a graduate of Capitol City Business College.

Chester is also survived by daughters, Barbara Jean Isner of Martinsville, Ind., Jane Henchcliffe of Culpepper, Va.; five grandchildren; and five great-grandchildren.

Contributions may be made to Oakwood Baptist Church, 855 Oakwood Road, Charleston, W.Va. 25314 or Kanawha Hospice Care, 1143 Dunbar Ave., Dunbar, W.Va., 25064.

Richard C. Wallace, M.D.

Dr. Richard C. Wallace, 74, of Hurricane, formerly of St. Albans and a family physician there for many years, died January 13 at Putnam General Hospital of heart disease.

Dr. Wallace was a graduate of Marshall College, WVU School of Medicine and the Medical College of Virginia. He interned at Ohio Valley Medical Center in Wheeling.

During the occupation of Japan after WWII, Dr. Wallace went to Yokohama on Christmas Eve in 1947 as part of the Army Medical Corps. His wife joined him about a year later.

When they returned from Japan, Dr. Wallace joined the medical staff at Thomas Memorial Hospital, where he served 35 years and was chief of staff in 1963.

Dr. Wallace was a member of the WVSMA, AMA, Kanawha Medical Society, and the WV Chapter of the American Family Physicians. He was a charter Fellow of the AAFP, a past president of St. Albans Rotary, and a member and past deacon of First Presbyterian Church in St. Albans.

Surviving are his wife, Mary Duke Wallace; sons, Dr. J.W. "Scott" Wallace of Charlotte, N.C.; and Dr. R. Austin Wallace of Charleston; sister, Edna Bedinger of Brandenton, Fla.; brother, Dr. Kenneth K. Wallace Sr. of Norfolk, Va.; and five grandchildren.

The family suggests contributions to St. Albans Rotary Scholarship Fund, P.O. Box 881, St. Albans, W.Va., 25177.

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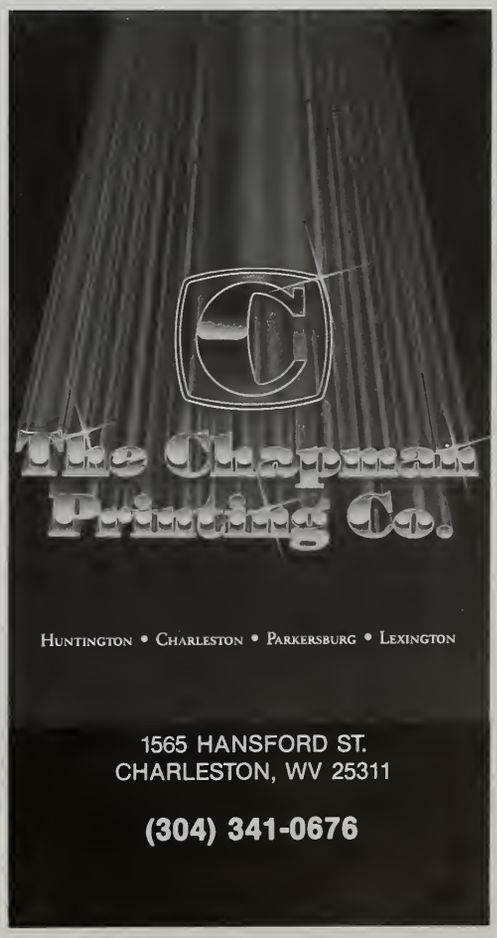

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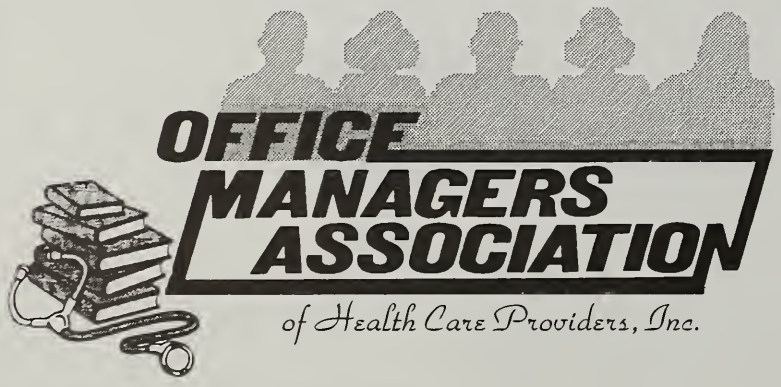

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(ISSN 0043-3284) is published bimonthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on the condition that they are contributed solely to the *West Virginia Medical Journal.*

The views expressed in the *West Virginia Medical Journal* are those of the individual authors and do not necessarily reflect the policies or opinions of the *West Virginia Medical Journal,* its editor, associate editors or staff, or the West Virginia State Medical Association and its staff. Publication of advertisements is not to be deemed an endorsement of any product or service unless otherwise stated.

POSTMASTER: Send address changes to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

USPS 676 740
ISSN 0043 - 3284

Subscription Rates: $45 a year in the U.S.; $80 a year in foreign countries; $4 per single copy. Address communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication and mailing costs, the *West Virginia Medical Journal* will not honor claims for back issues for any reason, unless these claims are received within a 6-month period after issue of the publication requested.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

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Front Cover

A red peony hints that the start of summer is near. Photo by Nancy L. Hill, managing editor of the West Virginia Medical Journal.

Dr. George Maxwell: Portrait of a family doctor

JEFFREY M. JONES, M.D.
Neurologist, Battle Creek, Mich.; Member, Board of Directors, Michigan State Medical Society

Editor's Note: The demand for primary care physicians continues to increase, but unfortunately the old family practitioner is fading away. As new systems for health care delivery develop, we would like to take a look at an example of a physician of a passing era. This article was written by Dr. Jeffrey M. Jones who grew up in Morgantown, W.Va., and graduated from the WVU School of Medicine in 1976.

Dr. George R. Maxwell

Dr. George Ralph Maxwell, *"Dr. Ralph"* as my mother called him, graduated from West Virginia University with a B.S. degree in 1921. He then received his M.D. degree from the University of Cincinnati in 1923, the same year my mother was born.

After interning at Grant Hospital in Columbus, Dr. Maxwell returned to Morgantown to practice with his father, Dr. Cyrus H. Maxwell, who served as president of the WVSMA in 1931.

My parents moved from Columbus to Morgantown in 1947 when I was just three-months-old, and bought a house which luckily turned out to be just a playing field and one house away from where Dr. Maxwell lived with his wife, Florence, and their two children, Mary and George. As a result of living so close to Dr. Maxwell, as well as his fondness for house calls, we rarely had to visit his office. When my sister, Jane, or I were sick, he would just stop by on his way home from work.

Dr. Maxwell was thin, pale and stood only four feet, eleven inches tall. He was very soft spoken and always wore a three-piece suit, except during the month of December when a bright red vest replaced the dark one.

Even though I was very young when Dr. Maxwell started caring for us, I never remember being scared of him. Jane told me that she would hide in the closet whenever I would have to get a shot because she afraid for me. I, though, never had such fears for her because I trusted Dr. Maxwell so much. In addition, if we did not need a shot, Dr. Maxwell would give us sugar pills which he carried in his Upjohn alligator doctor bag. It was my first experience with the often powerful placebo effect.

A prime example of how at ease I was with Dr. Maxwell happened when I was just three. I had seen my first minor league baseball game that day and noticed how close catchers squatted behind batters. That evening, I naturally assumed that close position when I was playing with my buddy Skip, who immediately swung the bat back and hit me in the head. My parents took me over to Dr. Maxwell's house, and I didn't even cry while he sewed up my bleeding head without anesthesia as I lay on the sofa in his family room.

When I was 8, a friend and I were climbing trees behind Dr. Maxwell's house. I grabbed a dead branch and fell backwards more than 20 feet, landing on my head! Danny ran away and left me to wander home in a daze. He later said he thought I was dead and did not want to get blamed. My mother knew something was wrong when I wanted to take a nap and immediately drove me to Dr. Maxwell's office. He patiently and persistently questioned me until I finally remembered where I had fallen and what had happened.

As an adult, Dr. Maxwell's caring and compassionate manner continued to have a profound effect on me. In 1972, a week after I returned from serving in Vietnam, my father, who had never experienced any health problems, had a major heart attack in the early morning hours. An ambulance rushed him to the county hospital where Dr. Maxwell was there to meet us. Dr. Maxwell did everything he could for Dad, but his heart damage was too great, and he died within a fews days. Throughout this devasting time, it was Dr. Maxwell's presence that greatly comforted us and helped us deal with the shock of Dad's illness and death.

When he retired on July 1, 1975, Dr. Maxwell was 77 and he had practiced medicine in Morgantown for more 50 years and been one of the first internists in the state certified by the American Board of Internal Medicine. He had taught at WVU as a clinical associate professor of medicine from 1926-1969, and operated a chest clinic for the public in Morgantown for 50 years, and one in Fairmont for 30 years. The recipient of many awards for his work with the Monongalia County Tuberculosis and Respiratory Disease Association, Dr. Maxwell also served two terms as president of the West Virginia Tuberculosis Association and the West Virginia Thoracic Society. In addition, he had been a member of the WVSMA Council and was active in several national organizations.

I was a third-year med student at WVU when he retired, and I was very proud to be among the 400 guests at a dinner in his honor at the VFW Hall in Morgantown. As I listened to him talk about the changes that had taken place in medicine over the years, I realized what a giant he was to me and all the other people in the room because he had touched our lives in so many ways.

Before he died unexpectedly less than six months later, Dr. Maxwell gave me a wonderful gift - - his medical bag and some of his old equipment. No matter how many times my wife tells me to throw away *"this old junk,"* I resist because they remind me that there is magic in doing work you enjoy.

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Implications of patient selection and surgical technique for primary total knee arthroplasty

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Wheeling

Abstract

Between 1983 and 1992, one surgeon at Wheeling Hospital in Wheeling, W.Va., performed 121 primary cruciate-sparing total knee arthroplasties on patients with degenerative joint disease. Rigorous preoperative screening criteria and surgical protocol were developed to improve the clinical lifespan of the joint replacements. The average range of motion increased from 99.8° to 107.1° during a mean clinical follow-up period of 40.5 months (range 12-144 months). Among the 86 patients with a preoperative fixed flexion contracture, the average improvement in flexion was 12.0°. Twelve of the patients developed postoperative medical complications, including two revisions of plastic tibial trays. The relatively low revision and complication rates are attributed to the experience of one surgeon utilizing similar guidelines for deliberate patient selection, preoperative educational programs, standardized operative protocol and surgical technique, and prosthesis familiarity.

Introduction

Cemented total knee arthroplasties have been conducted since 1971 and results from its continuing development suggest that the procedure can be as successful as cemented total hip arthroplasties (1). Total knee replacements can provide increased stability, correct postural deformity, render a useful range of motion, and possibly grant relief from perceived pain (2,3).

Numerous follow-up studies of total knee arthroplasty patients have appeared in the literature based on their surgical, clinical, demographic, or pathological assessment. However, it is difficult to compare the statistical results between different institutions and prostheses. The life span of the implant may depend on factors such as the patient's age, gender, weight, level of activity, diagnosis, component cementing, and the prosthesis used.

Efforts have been made to standardize the method of statistical analysis and roentgenographic evaluation both objectively and subjectively with knee-joint rating systems (4). The definition of failure used is of particular concern and includes revision of the implant, radiographic evidence of loosening, certain levels of expressed pain, or particular scores from rating systems. Survivorship analysis is the preferred method of review and was shown to be effective in comparing the results of different prostheses, populations, or institutions, even though many orthopedic patients die or are lost to follow-up due to unrelated causes (5,6).

This article presents our retrospective study of 121 total knee replacements in which we focused on the results of a single surgeon who used one type of prosthesis and instrumentation system over a 10-year interval. It discusses the various factors of the technique developed, and provides a rough comparison of studies involving multiple attending surgeons and senior residents at large institutions with regard to revision and range of motion data.

Methods

From August 1983 to August 1992, 121 primary total knee arthroplasties were performed by one surgeon in a solo practice of general orthopedics at Wheeling Hospital, a residential hospital located in Wheeling, W.Va. Since many factors such as age, weight, and level of activity have been implicated in the success of various implants, the initial surgeries were performed conservatively in an attempt to reproduce the success rates reported in the literature by large institutions (5).

Specific criteria desired in candidates for arthroplasty included patients 200 pounds or less who were 65 years or older, retired, and diagnosed with tricompartmental degenerative joint disease. Secondarily, a rough psychological assessment of each candidate was made. The patients selected for the procedure demonstrated a desire to undergo the preoperative teaching and complete the rigorous postoperative physical therapy program. A total of 88 of the 121 patients (73%) in this study fit all these criteria prior to undergoing the procedure.

These patients were educated about total joint replacement by watching videos and by reading literature which they were encouraged to review with family members. They were also given the Howmedica Total Knee Replacement Test™ and consent forms to further evaluate their willingness to undergo the procedure and rehabilitation.

Some patients requested and were given the names and phone numbers of previous "total knee patients" to discuss the procedure. Many patients concluded that they were not ready to make the commitment necessary and opted for other non-invasive measures, including weight-loss programs and physical therapy methods. Thus, patients in this study made informed, deliberate decisions to undergo total knee arthroplasty. In addition, the operative surgeon actively decided which patients were not appropriate candidates for the procedure.

Each prosthesis used was the Porous Coated Anatomic™ type from Pfizer Howmedica in Rutherford, N.J. They were surgically implanted according to the methods described by Hungerford and others throughout the modification and improvement of the implant design (7,8,9,10). The first 32 knees (26%) had metal-backed,

two-pronged patellar components, and all subsequent prostheses had polyethylene patellar components.

The decision regarding cementation of the femoral component was made intraoperatively. In the first years of the study, all components were cemented with methyl methacrylate. As optimistic studies of non-cemented components were reported, both options were utilized. If the bone stock was determined to be solid enough to accept an uncemented femoral component and it fit snugly during the trial fitting, the cementless technique was used for the femur. These were considered "hybrid" knees. By the conclusion of this study, 78 of the knees had undergone complete cementation of all components (64%), and the other 43 knees were of the "hybrid" type (36%).

The surgical environment and protocol were strictly regulated. All patients were cleared by a medical consultant before surgery since they were elderly and had other medical problems such as hypertension, diabetes, asthma or had suffered myocardial infactions, strokes or deep vein thromboses. Beginning in January 1986, patients were started on Coumadin 10 mg the night before surgery and then immediately postoperatively, keeping the Protime approximately 1.5 times normal for six weeks. A volunteer group of operating room nurses was used in each case, resulting in a staff familiar with the standard operating protocol. The operating room was sealed when surgery began, personnel changes were forbidden throughout the procedure, and no talking other than that necessary for the passing of instrumentation was allowed.

After fitting the trial components, the tourniquet was deflated to re-establish hemostasis before cementing. The tourniquet was then reinflated and the prosthesis removed from the sterilized package. Separate batches of methylmethacrylate were made for each component to facilitate an even consistency during the final placement of each component. Many patients (93%) underwent release of the lateral retinaculum of the patella due to tracking.

Postoperatively, patients were kept in Jones dressing with anterior and posterior splints. Starting in December 1985, patients were placed on a continuous passive motion machine for alternating two-hour intervals during the waking hours. The average hospital stay after surgery was eight to 10 days, and outpatient rehabilitation was arranged with a physical therapist to improve the active range of motion. Furthermore, bilateral replacements were staged at six-month intervals to achieve rehabilitation in the first knee prior to the second replacement.

All patients were subsequently examined by the operative surgeon at six weeks, four months, eight months, one year, and every two years. Supine and anteroposterior radiographs were taken at each visit to monitor the component positioning. After six months, the anteroposterior X-rays were taken with the patient standing. Objective data were obtained relative to range of motion, stability, roentgenographic evidence of loosening, the need for walking aids, and the patient's ability to perform his/her daily tasks. Subjective data were collected relative to pain and discomfort over the patellar area during normal activities, as well as the patient's personal assessment and evaluation of the implant.

The demographic characteristics of the patients used in the study are found in Table 1. Only patients with a follow-up period of at least 12 months were included to allow an adequate frame of observation relevant to the result of the arthroplasty. Sixty-one (50%) of the knee replacements have been followed successfully for at least three years, and 26 of the knees (21%) have been followed successfully for at least five years, with a mean follow-up of 40.5 months. The time frame refers to the period from the arthroplasty to the last follow-up visit. In many cases, the arthroplasty remained functional longer than is indicated, but the patient died or was lost to follow-up.

Table 1. Profile of the 121 Patients Who Underwent Primary Total Knee Arthroplasties

Characteristics
Number of Males – 40 (33%)
Number of Females – 81 (67%)
Age, mean (range) – 70.9 yrs.(42-89 yrs)
Weight, mean (range) – 79.4 kg (43-138 kg)
Height, mean (range) – 162.8 cm (145-185 cm)
Number with osteoarthritis – 109 (90%)
Number with rheumatoid arthritis – 12 (10%)
Initial range of motion, mean (range) – 99.8° (40-138°)
Number with patellar component cementing – 78 (64%)
Number with hybrid knees – 43 (36%)
Length of clinical follow-up, mean (range) – 40.5 months (12-144 months)

In accordance with other studies, medical complications were used as the endpoint of failure for statistical analysis of the clinical results. The benchmarks used to indicate failure of the implant included revision or recommended revision of the knee; infection of the knee; postoperative active range of motion less than 90°; the presence of radiolucent lines greater than 2 mm; and unresolved pain.

Results

Figures 1a-1c show pre and postoperative X-rays of the first total knee arthroplasty in this series. Clinical follow-up of all 121 total knee replacements resulted in two revisions and 10 other postoperative medical complications.

The first revision that was necessary occurred three years after the initial total knee replacement. This patient was doing well for 2 years after the surgery and then thought she "pulled something in her knee." An X-ray taken with this patient bearing her weight indicated medial subluxation of the tibia in relation to the femur, suggesting lateral wear of the original 9mm plastic tibial plateau. During surgery, the initial plastic tibial plateau tray indicated significant polyethylene wear and was replaced with a larger, 19mm constrained plastic insert. Neither the femoral nor tibial metal components were changed during the revision of the plastic insert. The radiographs in Figures 2a-2d show the progression of the knee before and after the primary arthroplasty and the revision. One year after the revision, a weight-bearing film showed preservation of the alignment.

The second revision occurred in an active 65-year-old man nearly three years after the total knee replacement. Weight-bearing films suggested a narrowing of the medial compartment of the plastic tibial tray, but he did not express severe discomfort. Exploratory surgery confirmed the polyethylene wear and the 9mm plastic tibial tray was replaced with a new plastic component. The femoral and tibial metal components were not changed.

Figure 1a. Preoperative weight-bearing anteroposterior radiograph of both knees shows 31° valgus in 1982.

Figure 1b. Postoperative radiograph in 1983 shows the tibial component was of the stem-base plate type.

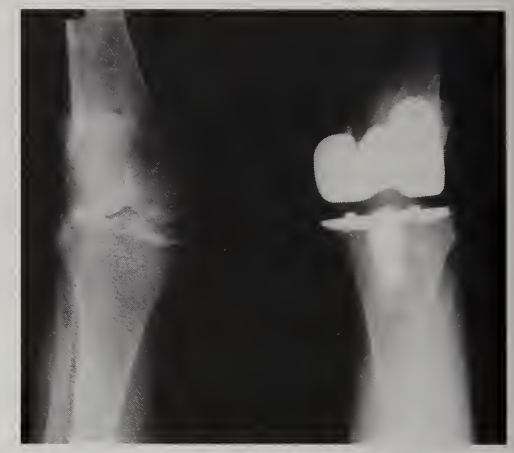

Figure 1c. X-ray 10 years after surgery shows deterioration of the knee bone stock but stability of the prosthesis.

Two postoperative infections (1.7%) also occurred. An 82-year-old patient did not disclose his chronic alcoholism to the operating surgeon or the medical consultant until the patient experienced alcoholic withdrawal syndrome several days postoperatively. Four months after the arthroplasty, he was hospitalized for pneumonia. Eight months postoperatively, this patient had swelling and infection of the knee with *Enterococcus faecalis.* It was controlled with irrigation, debridement, and long-term IV antibiotic treatment after the patient refused a revision of the prosthesis. He showed no further complications with the prosthesis for two years until his death from unrelated causes.

Another patient developed a Group *D Streptococcus* infection three years after the total knee replacement and was treated with six weeks of intravenous antibiotics. The infection recurred five months later and was finally resolved with another six weeks of I.V. antibiotics.

Other postoperative medical complications which developed included superficial or deep vein thrombosis in four patients (3.3%), and pulmonary emboli in two patients (1.7%). These complications were resolved in all six patients by treating them with intravenous anti-coagulants and Heparin followed by Coumadin taken orally.

In addition to the two revisions, the two infections, the four cases of superficial or deep vein thrombosis, and the two patients who developed pulmonary emboli, there were also three patients whose arthroplasties (2.5%) resulted in a range of motion less than 90°. One of these patients had a three-month 10-80° arc of flexion, was manipulated under anesthesia to 0-95°, and has maintained this level of motion. Another patient with rheumatoid arthritis, chronic renal failure, and steroid dependence had a quadriceps rupture two months postoperatively and was only able to regain a range of motion of 40-100°.

A third patient with limited motion had a manipulation under anesthesia four months after surgery and regained 0-85°. The range regressed, so a Thompson quadriplasty was performed. This patient's range of motion initially improved to 0-90°, but was only 0-70° at the final follow-up.

No patients were determined to fit the other definitions of failure. Thus, no follow-up radiographs indicated the presence of radiolucent lines exceeding 2mm, and there were no patients at their final follow-up visit who indicated they had pain related to the arthroplasty.

Statistical analysis

In patients that had a fixed flexion contracture before the arthroplasty, there was a negative correlation between the initial range of motion and the gain in flexion after the knee replacement (-0.655 [$p < 0.0001$]). This indicated that the less functional the knee was preoperatively, the greater the probability of reducing the fixed flexion contracture and improving the mobility of the knee.

There also was a statistically significant increase between the initial range of motion (99.8°) and the range of motion (107.1°) at the final clinical follow-up evaluation ($p = 0.0001$). A whole-model analysis of variance (ANOVA) suggested a dramatic combined effect of six characteristics (sex, age, weight, preoperative diagnosis, initial range of motion, and patellar cementing) on the final range of motion ($p = 0.0007$). Individually, however, these characteristics did not affect either the final range of motion or the gain in fixed flexion contracture.

Other variables, such as the release of the lateral patellar retinaculum and the use of continuous passive motion showed no statistical relevance to the final functional result.

Discussion

At all follow-up visits, most patients expressed satisfaction with the results of their knee surgery, and stated they had little or no pain and were sufficiently mobile to perform their daily activities. Since all arthroplasties were performed and evaluated by one surgeon in a private setting, there was the possibility of bias in the evaluation process, but most of the subjective evaluation of pain and mobility relied on the patient's opinion as documented in their charts.

The clearly defined and reproducible end point of revision or recommended revision was not applicable to these results since it occurred in only 1.7% of the cases. According to Dorey and Amstutz, very little relevance can be placed on survivorship curves in which very few failures, such as less than 10, are present (6). Therefore, with only two revisions, survivorship analysis was deemed not reliable and more qualitative methods of analysis were employed.

A variety of factors may have contributed to the relative success of the arthroplasties in this study. The fact that preoperative diagnosis, age, sex, weight, height, cementing, and months of follow-up did not affect the outcome individually could be a result of the rigorous preoperative screening and selection of patients. Perhaps these variables were

Figure 2a. Preoperative weight-bearing AP X-ray showing arthritis in the knee.

Figure 2b. Postoperative X-ray of the initial knee replacement taken with the patient not bearing weight.

effectively minimized by their combined influence on the outcome. The evidence of a desire to complete the physical therapy and regain full functionality may be more important than other prognostic variables.

It is difficult to compare the outcomes of patients with osteoarthritic or rheumatoid joints with other patients who undergo arthoplasties since osteoarthritic joints generally have a better bone stock. In our study, 90% of the arthroplasties were performed on tricompartmental osteoarthritic knees, and the others were affected by rheumatoid arthritis. In another

Figure 2c. Weight-bearing X-ray two years after surgery indicating the subluxation of the initial knee replacement.

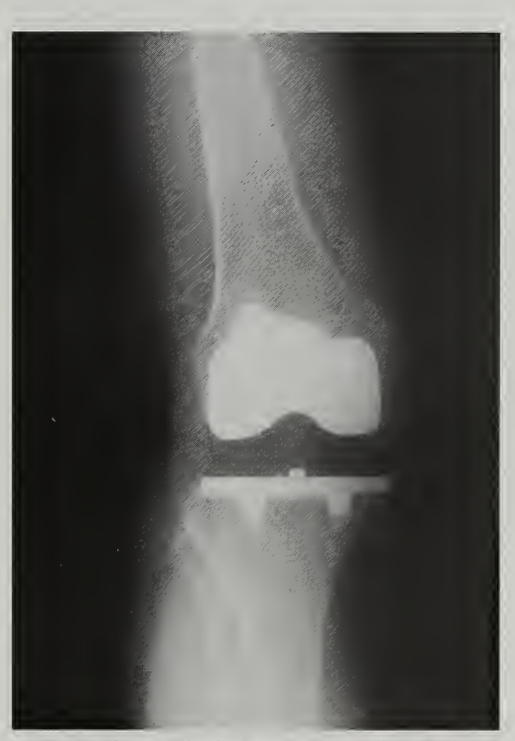

Figure 2d. Weight-bearing AP radiograph 12 months after conversion of the tibial plastic insert to the thicker component. Neither the femoral nor tibial components of the original prosthesis were changed during the revision surgery.

study, Callahan and colleagues reported that studies enrolling a higher proportion of osteoarthritic patients tended to report more favorable outcomes (11).

Several studies have implicated age in the clinical success rates of total knee arthroplasties, but with conflicting conclusions. Scuderi et al reported no difference in the success of knee replacements between patients younger than 55 years old and those over 55 years old (2). However, in a Swedish study of 8,000 cases, the implant survived significantly longer in patients who were over 65 years old than in younger patients (12). Another study of 9,200 cases at the Mayo Clinic showed significantly lower ($p < 0.0001$) rates of survival in patients who were less than 60 years old and expressed caution in considering total knee replacement in younger patients (13).

To gain further perspective on this subject, a meta-analysis of 130 different published studies was conducted which reported the following results (11):

1. A positive correlation between mean patient age and the percentage of patients with good or excellent outcomes (0.27 [$p = .007$]);
2. A negative correlation between mean patient age and the percentage of knee revisions (-.31 [$p = .002$]).

Given these findings, the relatively high average age of 70.9 years in our study may have contributed to the clinical success rate. In addition, some patients were advised to wait until retirement or until their activity level decreased to undergo the procedure.

Gender was not a preoperative concern except when related to activity level, but patients weighing less than 200 pounds were sought to reduce the stress on the implant. It is also important to consider the fact that a greater proportion of the knees near the second half of the study were considered "hybrid" knees with non-cemented femoral components. Even though there was not a clearly defined statistical difference in the outcome between cemented and hybrid knees, the hybrid knees did yield a higher average final range of motion at the last follow-up ($p = 0.12$). This outcome is probably not a function of the prosthetic components, but rather due to the surgical indications for the intraoperative decision of cementing. Since hybrid knees usually consist of better femoral bone stock and a more solid fit, we suggest the need for a stratification, co-variate adjustment, or multivariate analysis to determine the exact significance of this factor.

Another factor which may have contributed to our high success rate was that patients were encouraged to

alleviate as many social and work-related problems as possible before surgery. Working patients planned postoperative job limitations or problems with their employers to eliminate any ensuing legal or psychological ramifications. Even some of the obese, younger patients who had knee replacement due to severe arthritis progressed well when they returned to work because of this factor.

Obviously, our patient group was deliberately biased because of factors such as these and the other steps taken pertaining to patient selection, the nursing staff, and the hemostasis between trial and actual component implantation. This is an important consideration when comparing our results with other studies. Wright et al (14) emphasized the routine for patient selection. A contradictory study by Scuderi and Insall (2) suggested that component positioning, knee alignment, and other surgical elements are more influential on success rates than diagnosis and personal patient characteristics.

Two final factors that may have influenced the observed success rate of our study were the design of the prosthesis and the instrumentation, and the use of the continuous passive motion machine. The consistent use of the Porous Coated Anatomic™ prosthesis and Universal Total Knee Instrumentation System™ was intended to increase the surgeon's familiarity and skill with the procedure. It facilitated the development of speed, accuracy, and confidence with the instrumentation in a systematic approach, and also helped the operating staff become familiar with the technique and protocol of the surgery. Even though slight modifications were made to the prosthesis over the 10-year period of our study, they did not affect the technique or instrumentation, or have a significant effect on the functional result of the procedure.

The minimal benefits we obtained in improving patients' functional results by using the continuous passive motion machine supported the findings of another study (15). However, it has been shown to expedite initial rehabilitation and initiate physical therapy faster so hospitalization is shorter -- an important consideration in today's managed care environment.

Conclusion

Results from other studies can be loosely compared to findings in this study. Callahan and colleagues discussed 61 different studies on more than 3,600 patients who received posterior cruciate ligament-preserving prostheses, of which the Porous Coated Anatomic™ implant was included.

The groups in the Callahan study averaged 59 patients with a mean age of 65.2 years and 3.9 years of follow-up. There were complications in 12.9% of these knees, 3.0% required manipulation under anesthesia, and 4.2% necessitated revision. These statistics compared to 10.7%, 1.7%, and 1.7%, respectively, in our study. Callahan also reported that PCL-preserving prostheses resulted in higher mean knee-rating system scores and fewer postoperative medical complications than other varieties of prostheses (11).

A very wide range of success rates and survivorship curves has been reported for the hundreds of prosthesis types. Studies cite component improvements, instrumentation, and surgical technique in the increasingly predictable results from total knee arthroplasty. Though a much larger sample would be necessary to establish statistical significances between the various prognostic variables, the selectivity and deliberation with which this sample was comprised may have contributed to the general success rate. Ideal candidates for the procedure were considered to be retired adults 65 years and older, who weighed less than 200 pounds and were motivated to rehabilitate the knee. Though this patient cohort was not entirely homogeneous, the low number of revisions and complications is especially encouraging for the future of total knee arthroplasty.

During the 1970s and early 1980s, the total knee replacement was not comparable to the total hip replacement in reproducibility or long-term results. Recent studies such as ours suggest methods to reverse that trend and provide a reliable surgical option for a common orthopedic problem.

Acknowledgement

The authors thank Kevin France and Pfizer Howmedica, Inc. for providing background information, videotapes, and other resources for this study.

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Juvenile polyps and their distribution in pediatric patients with gastrointestinal bleeding

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Abstract

Juvenile polyps (JPs) are the most common colonic tumor in childhood. The total number and anatomical distribution have changed significantly since the introduction of flexible colonoscopy. This article reviews our experiences treating 29 pediatric patients with JPs, and evaluates the 66 polyps we removed and their distribution in the colon. Thirteen patients (45%) had multiple polyps and 35% of all polyps were found proximal to the sigmoid colon. In the 14 patients who underwent a complete colonoscopy, eight had multiple polyps and 55% of these polyps were found proximal to the sigmoid colon. As a result, we conclude that there is a trend toward more polyps per patient and a more distal colonic distribution in children with JPs than previously reported. We recommend that a complete colonoscopy and possible polypectomy be performed on all children with unexplained rectal bleeding.

Introduction

Juvenile polyps (JPs) are the most common tumor of the colon in childhood, occurring in 1%-2% of children (1-4). In the past, JPs were described as benign hamartomatous lesions with negligible potential for cancerous changes. Nevertheless, patients with neoplastic transformation have been described (5-8). These reports resulted in the recommendation for removal of every polyp in a child over eight years of age and close observation for one year in younger children (9).

JPs have been described mainly in the distal colon. Mazier et al (10) reported in 1982 that 60% of the polyps they found in 258 patients were located within 10 cm of the anal verge. Only 10% of JPs were further than 20 cm away from the anus. Other studies confirmed this finding (11,12), however, in recent studies the number of JPs proximal to the sigmoid colon has been reported as high as 60% (13,14).

This article reviews our experience in treating 29 pediatric patients with JPs, and evaluates the 66 polyps we removed and their distribution throughout the colon.

Materials and methods

The charts of all patients who were diagnosed with a juvenile polyp between 1985 and 1994 at Cabell Huntington Hospital in Huntington, W.Va. were reviewed. There were a total of 29 patients (male/female ratio 1.07, mean age of 7.7 years), who were diagnosed with JP in that period and 14 of them underwent complete colonoscopy and 15 had a partial colonoscopy (Table 1). The main clinical presentation was rectal bleeding of varying duration.

A barium enema was performed on 22 of these patients prior to endoscopy, and 14 (64%) were positive for polyps. In the complete colonoscopy group, 10 children (71%) had a barium enema and 7 (70%) of them were positive for a polyp.

Results

A complete colonoscopy was performed in 14 patients, and 15 patients had a partial colonscopy (hepatic flexure 2, transverse colon 5, splenic flexure 4, and sigmoid colon 4) because they could not tolerate pain or had difficulty as the colonoscope advanced (Table 2). There was no significant difference between the patients who underwent complete or partial colonoscopy in sex, gender or presenting symptoms. Patients with a family history of polyposis or colon cancer were more likely to have a complete colonoscopy.

A total of 66 polyps were discovered as a result of the colonscopies, and 23 (35%) were located proximal to the sigmoid colon (Figure 1). Sixteen of these children had a solitary polyp, while 13 had an average of 3.8 polyps. Of the patients who had complete colonoscopies, 57% had multiple polyps and the majority (55%) of them were proximal to the sigmoid colon. Histologically, all polyps were benign retention polyps ranging from 0.3 cm to 4.0 cm in diameter.

The patients who underwent total colonoscopy had a higher percentage of multiple polyps (57%) compared to those who had partial colonoscopy (33%). However, this difference was not significant ($p = 0.2$). In children who had multiple polyps, the average number of polyps per patient was slightly higher in the complete colonoscopy group compared to the partial colonoscopy group (4.0 vs. 3.6).

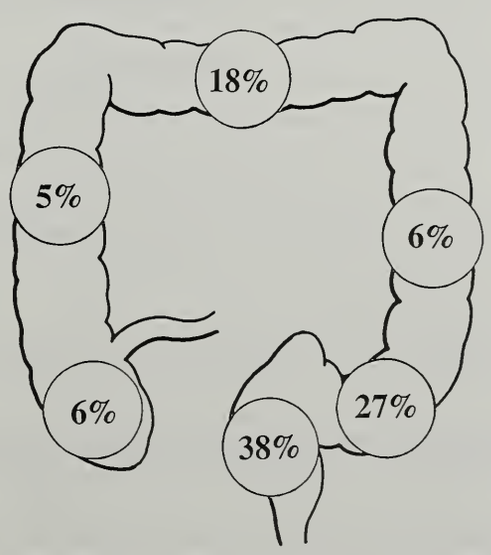

Figure 1. Anatomical Distribution of JPs in the Colon.

Discussion

JPs are the most common tumor of the colon in childhood with an occurrence of 1%-2% in asymptomatic children (1,2). The peak incidence of JPs occurs at four years of age (10), and the most common presenting complaint has been described as rectal bleeding, followed by protrusion of the polyp, passing of polyp tissue, and abdominal pain (1,10). In our study, all children diagnosed with a JP presented with rectal bleeding, but only 10% complained about abdominal pain.

Macroscopically, the JPs are usually round with a smooth, continuous surface (15). Histologically, JPs consist of epithelial and connective tissue elements. Acute or chronic inflammatory cells and infiltration by eosinophils are frequently observed (13,15).

Table 1. Characteristics and Symptoms of the 29 Pediatric Patients Undergoing Colonoscopy for Juvenile Polyps

	Partial Colonoscopy	Complete Colonoscopy
Male	9/15 (60%)	6/14 (43%)
Female	6/15 (40%)	8/14 (57%)
Mean Age in Years (Range)	6.7 (2.9 - 15.4)	8.2 (1.5 - 16.5)
Family Hx of Colon CA	2/15 (13%)	4/14 (29%)
Family Hx of Polyps	0/15 (0%)	3/14 (21%)
Previous Hx of Polyps	0/15 (0%)	1/14 (7%)
Presenting Symptoms		
Rectal Bleeding	15/15 (100%)	14/14 (100%)
Abdominal Pain	1/15 (7%)	2/14 (14%)

Table 2. Colonoscopy Results for the 29 Pediatric Patients

Distance	Number of Patients	Percent
Complete	14	48%
Hepatic Flexure	2	7%
Transverse Colon	5	17%
Splenic Flexure	4	14%
Sigmoid Colon	4	14%
Total	29	100%

Juvenile Polyps	Partial Colonoscopy	Complete Colonoscopy
Total Polyps (Mean)	28 (1.9)	38 (2.7)
Solitary	10 (67%)	6 (43%)
Multiple	5 (33%)	8 (57%)
JPs Per Patient (Range)	3.6 (2-6)	4.0 (2-7)

The number and anatomical distribution of JPs have changed significantly over the years. In the pre-colonoscopy era, single polyps were reported in the majority of patients (65%-80%)(1-4,12,14). However, with the improvement of flexible colonoscopes, a higher prevalence of multiple JPs (40%-60%) has been described (13,16). In concurrence with the most recent data, we found multiple JPs in 45% of our patients. The patients who underwent complete colonoscopy had an even higher percentage of multiple polyps (57%), which suggests that more JPs will be revealed with complete vs. partial colonoscopy.

The average number of JPs was previously estimated between 1.2 - 2.0 per patient (12,13,16). In our study, the average number of polyps per patient was 2-3. This suggests that the earlier studies, especially those prior to the flexible colonoscopy era, resulted in an underdiagnosis due to technical difficulties and incomplete evaluations. Concurring with this theory, a higher number of polyps per patient was found in the group that underwent complete colonoscopy compared to partial colonoscopy.

Reports in the literature about the number of polyps and their distribution have changed over the years. In the past, up to 80% (range 65%-80%) of pediatric patients with JPs presented with a single polyp at the time of diagnosis (1-4). Approximately 60% of the JPs were found within 10 cm of the anal verge and only 10% were scattered throughout the colon proximal to 20 cm from the anal verge (1-4,17,18). Only one study, published in 1986, indicated there was a higher percentage (up to 60%) of JPs proximal to the sigmoid area (13).

In our study, a total of 23 polyps (35%) were found proximal to the sigmoid colon, but this number may be underestimated since only 48% of our patients had the entire colon investigated. In patients who underwent complete colonoscopy, 45% of all polyps were found proximal to the sigmoid colon. Overall, the trend of proximally distributed JPs may suggest that the entire colon needs to be explored in patients suspected of these tumors.

All patients were histologically diagnosed with juvenile polyps and 31% of the patients had polyps with inflammatory changes. Although JPs are considered benign lesions, the risk of malignant transformation has been acknowledged. Anecdotal cases of carcinomatous degeneration in a single polyp in children have been reported (7,8). Premalignant changes, i.e. adenomatous polyps, have also been described (10,19,20). In fact, it is estimated that 3%-5% of solitary polyps in pediatric patients are adenomatous polyps (13).

The association between JPs and colon cancer development is a concern that has not been completely resolved. Although a previous study did not show any increase of colon cancer development in adult patients who had been diagnosed with solitary JP as children (21), Giardiella and colleagues published an article in 1991 (22) which considered multiple JPs and a positive family history of colon cancer as risk factors for cancer development. In addition, even though we did not find any premalignant or malignant changes in our patients, a third of them had a positive family history for colon cancer or colonic polyp. Moreover, we have previously shown an increased activity of pre-malignant markers, i.e. ornithine decarboxylase and tyrosine-kinase enzymes in solitary JPs compared to adjacent normal mucosa (23). To reduce cancer risk, it is therefore important to attempt complete colonoscopy and polypectomy in patients with JP.

Conclusion

Our study indicates that there is a trend towards a higher number of polyps per patient and a more proximal colonic distribution than previously reported. Considering the malignant potential of juvenile polyps, we recommend a complete colonoscopy in all children with rectal bleeding that cannot be explained

with conventional tests. Once a polyp is identified, polypectomy is warranted irrespective of macroscopic or histological appearance.

Acknowledgment

We would like thank Mrs. Ginger Charles, Mrs. Kathy Hudson and Mr. Larry Ball of the Medical Records Department at Cabell Huntington Hospital for their research assistance, and Mrs. Jennifer Long for her secretarial expertise in preparing this article.

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Bedside placement of polyglycolic acid mesh: A novel treatment of uncomplicated abdominal wound dehiscence

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Abstract

Uncomplicated abdominal wound dehiscence is a common problem in critically ill patients undergoing general surgical procedures. In the past, a majority of these patients have been subjected to an emergency return to the operating room for wound closure to prevent evisceration. In this article, we present two successful cases of a novel bedside approach using local anesthesia and polyglycolic acid mesh in uncomplicated abdominal dehiscence to prevent evisceration.

Introduction

Uncomplicated abdominal wound dehiscence (dehiscence that is not related to infection) complicates about 0.5% of major laparotomy incisions. The subsequent mortality of 15% is caused by factors such as starvation, uremia, anemia, shock, liver failure, obesity and advancing age that predispose patients to evisceration. Local factors are distention by ileus or ascites and the distruptive forces of coughing, vomiting or delirium tremens. Failure to repair dehiscence will result in eviseration in most cases (1), so patients are usually forced to return to the operating room (with its inherent anesthesia risk).

This article reviews our experiences stapling polyglycolic acid mesh to two patients' skin while they were in their hospital beds under local anesthesia. We cut the appropriate size of polyglycolic acid mesh to fit each wound, and then stapled it to the skin in this area (Figures 1,2). Within two-three weeks, the patients were protected against evisceration because granulation tissue formed through the polyglycolic acid mesh to allow skin grafting (Figure 3).

This simple technique is a variation on previously described mesh closures of the abdomen where fascial closure is performed with mesh (2). However, this technique has the advantage of being a simple bedside procedure that accepts the wound failure (hernia) while protecting against evisceration.

First case report

A 68-year-old woman with multiple medical problems including insulin dependent diabetes mellitus, severe rheumatoid arthritis and coronary artery disease, was admitted to Ruby Memorial Hospital in Morgantown because of complete intestinal obstruction. She had a previous surgical history of open cholecystectomy and appendectomy, and had physical findings consistent with intestinal obstruction.

This patient was hydrated and taken to the operating room where she was found to have multiple adhesions that were lysed without complication. After surgery, she became ventilator dependent and developed nosocomial pneumonia. In addition, she developed a wound and fascial dehiscence, which was evaluated and found not to be related to infection. Since she was on a significant amount of ventilatory support, the decision was made to perform the polyglycolic acid mesh closure of the skin at bedside in the ICU under local anesthesia.

After placement of the mesh, the patient continued to improve in a progressive manner. By two weeks, the granulation tissue had grown into the mesh and the excess mesh along the skin was excised. The granulated abdomen was skin grafted. She was discharged to an extended care facility six weeks after the placement of the skin graft.

Second case report

A 75-year-old man with insulin dependent diabetes mellitus and severe congestive heart failure presented to the Emergency Room at Ruby Memorial Hospital with partial intestinal obstruction. His history revealed he had experienced an abdominal aortic aneurysm which had been resected one year earlier. He had physical findings which were consistent with intestinal obstruction.

Figure 1. Abdominal wound dehiscence.

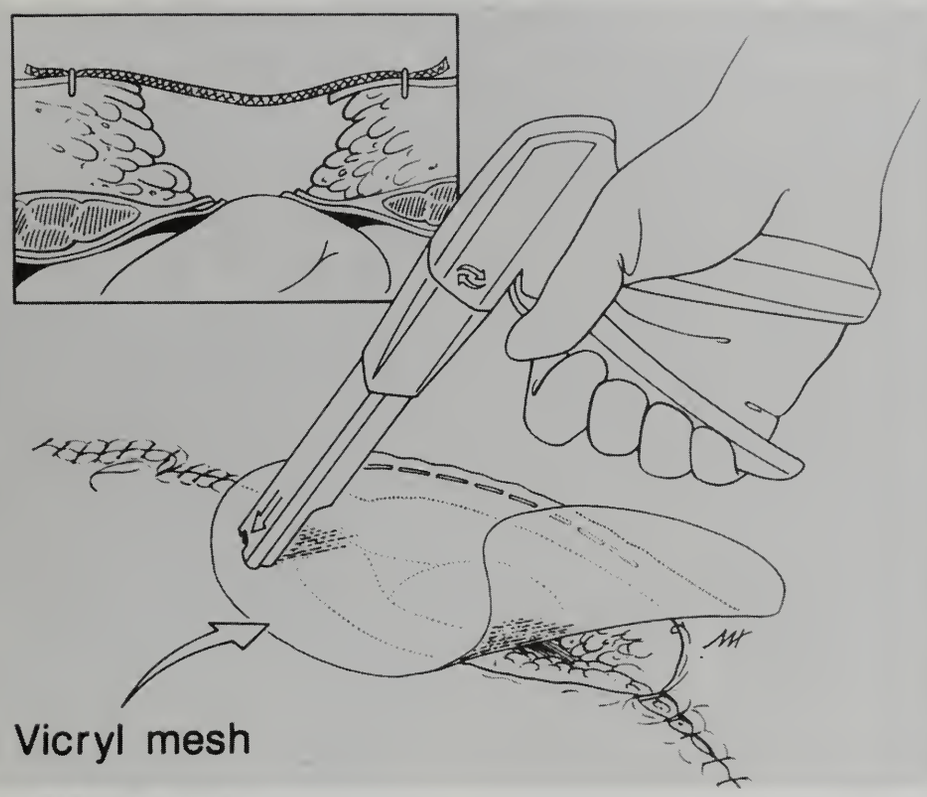

Figure 2. Mesh stapling to skin.

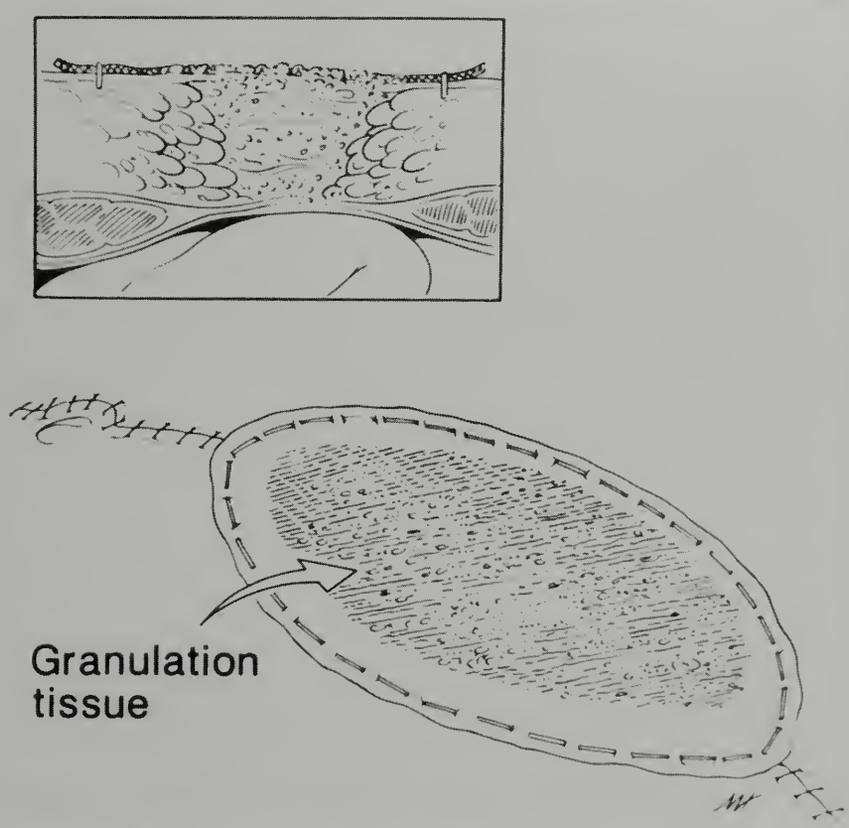

Figure 3. Granulation tissue 2-3 weeks later.

This patient was non-operatively managed for 12 hours without improvement, so he was taken to the OR for correction of the obstruction after cardiovascular stabilization. During surgery, an internal herniation of the small intestine was discovered which was corrected without complication. Postoperatively, he developed respiratory distress syndrome and nosocomial pneumonia. On the fifth day after surgery, this patient had an abdominal and fascial wound dehiscence. Work-up failed to reveal an infectious etiology. Since he was on significant ventilator support at the time, the polyglycolic acid mesh closure was performed at bedside in the surgical ICU under local anesthesia.

This patient progressively improved and three weeks after the mesh was placed, the wound had granulated through the mesh sufficiently for a skin graft. He was skin grafted and then discharged from the hospital to an extended care facility two weeks later.

Discussion

Polyglycolic acid mesh closure is recommended only for patients who have abdominal dehiscence without infection, a condition usually found in only 0.5% of cases (1). Elderly patients certainly have many of the risk factors associated with uncomplicated dehiscence and evisceration, but their multiple medical problems place them at a high surgical anesthesia risk.

While accepting the fascial dehiscence, this procedure eliminates the possibility of evisceration. It has the advantage of allowing granulation tissue to form through the polyglycolic acid mesh which is coarse. Since this mesh is absorbed (usually by three months), the possibility of infecting this foreign body is minimized.

Conclusion

This technique offers a viable bedside alternative to operative abdominal wound dehiscence. More prospective studies are needed to further evaluate this technique.

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The treatment of *Eikenella corrodens* soft tissue infection in an injection drug user

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Abstract

Eikenella corrodens *is a gram negative rod considered normal mouth flora and is commonly linked to human bite injuries. In rare cases,* E. corrodens *can cause systemic infections. This article describes the case of a 30-year-old injection drug user who presented with a serious polymicrobial infection of the arm. Usual empiric antibiotic coverage resulted in little improvement, and eventually 300 milliliters of purulent material was drained from his upper arm. Cultures of the drainage grew* E. corrodens *as well as other oral flora. After surgical drainage, specific antibiotic therapy directed towards* E. corrodens *was added to his antimicrobial therapy and the patient fully recovered. We conclude that* E. corrodens *is common in the injection drug user population as part of mixed infections, and that empiric antibiotic coverage for this organism, namely penicillin, may be warranted in certain clinical situations.*

Introduction

Eikenella corrodens is a slow-growing, facultative, anaerobic gram negative rod which was first described in 1958 by Eiken. It is part of the normal flora of the mouth and other mucosal surfaces (1). Typically, this organism does not cause clinical infections, but both isolated and mixed infections with it have been reported.

E. corrodens infections are more prevalent in injection drug users. According to recent surveys done by the West Virginia State Alcohol and Drug Abuse Department, injection drug use prevalence appears to be increasing in the state (2). As a result, these uncommon infections may be seen more frequently by primary care providers in West Virginia.

Case presentation

A 30-year-old white male who was an injection drug user came to the Emergency Department at Ruby Memorial Hospital in Morgantown because he had experienced pain and erythema of the left arm for five days. He had a three-year history of injection drug use, but denied sharing needles. Recently, he had been been injecting dissolved hydromorphone (Dilaudid) and oxycodone (Percocet) 5-15 times per day, and he admitted to using saliva in the injecting process.

This patient's past medical history was significant for a complicated cellulitis of his right upper extremity six months prior to this admission, alcohol abuse and a penicillin allergy. Two years earlier, this patient had received a tetanus booster, and within the past year he had tested negative for HIV.

Physical exam revealed an uncomfortable patient experiencing chills. His temperature was 37.8°C, pulse was 108/min., and respirations were 20/min. The exam of his head, neck, lungs and abdomen was normal, but he had a II/VI systolic ejection murmur. His entire left arm was erythematous, edematous and tender. There were no palpable cords, fluid collections, crepitus or involvement of the joints. Neurologic and vascular exams of the arm were normal. Many areas of the skin revealed "track-marks" and areas of ecchymosis.

Laboratory tests revealed a white blood cell count of 18,000µl, with 75% PMNs, and 7% band forms. Blood cultures, chest X-ray, electrocardiogram, echocardiogram, venous doppler and plain X-rays were all negative.

Intravenous vancomycin, gentamicin and clindamycin were started empirically to treat his cellulitis with little improvement. The erythema and tenderness localized and an ultrasound revealed a four centimeter subcutaneous fluid collection just above the antecubital fossa. This area was surgically drained and cultures grew *Peptostreptococcus, Proprionibacterium acnes* and *Eikenella corrodens*. There was no muscle involvement. Since he was allergic to penicillin, doxycycline was added to his antibiotic regimen for a total of 14 days and he fully recovered.

Discussion

Infections in injection drug users are much more common than in the general population, and injection drug use is becoming more prevalent in the United States (3). Some of the reasons for the increased prevalence of infections in injection drug users include humoral and cellular immune defects, non-sterile injecting techniques, contaminated paraphernalia, altered level of consciousness, alcohol abuse, poor nutrition and intermittent antibiotic use (4).

The most frequent reason for hospital admissions in injection drug users is soft tissue infections. Staphylococci and streptococci are the most common organisms isolated (4). Empiric antibiotic coverage typically includes vancomycin and gentamicin. Clindamycin may be added if anaerobic organisms are suspected.

E. corrodens infections are becoming more prevalent in injection drug users, and these organisms are often involved in polymicrobial infections, as in our patient's case. This may contribute to the increased virulence of this organism (5), and may also make it even more difficult to isolate, identify and eradicate.

When isolated in a lab, 45% of the isolates cause pitting of the agar surface, and there is the characteristic "musty odor" of "hypochlorite bleach" (6). Virulence factors include a slime layer and an active lipopolysaccharide (1).

Commonly isolated in periodontal disease, *E. corrodens* is classically associated with 25% of "clench-fist" injuries (7). However, it has also been isolated in infections of the eye, head, neck, lungs and thorax, heart and mediastinum, abdominal and gynecologic organs, and soft tissue/bone (1).

E. corrodens is generally susceptible to penicillin, ticarcillin, piperacillin, second and third generation cephalosporins, chloramphenicol, fluoroquinolones and tetracycline. We used doxycycline to treat the *Eikenella* in our patient because of his penicillin allergy. Vancomycin and the aminoglycosides are inactive (6). Clindamycin and metronidazole are

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Tablets and Oral Suspension

CEFZIL®

(C E F P R O Z I L)

Fights Infections* Fast!

*Mild to moderate pediatric respiratory tract infections.

Please see brief summary of Prescribing Information on the following page.

Tablets and Oral Suspension

CEFZIL®

(CEFPROZIL)

Fights Infections Fast!

- Oral suspension has great-tasting, bubblegum flavor
- Well tolerated in pediatric patients[1]
- Broad-spectrum *in vitro** activity for greater therapeutic assurance
- BID dosing schedule

*Although a useful guide, *in vitro* activity does not necessarily correlate with clinical response.

Reference: 1. Wilber RB, Doyle CA, Durham SJ, et al. Safety profile of cefprozil. *Clin Infect Dis.* 1992;14(suppl 2):264-271.

BRIEF SUMMARY
The following is a brief summary. Please consult complete Prescribing Information.

INDICATIONS AND USAGE
CEFZIL® (cefprozil) is indicated for the treatment of patients with mild to moderate infections caused by susceptible strains of the designated microorganisms in the conditions listed below:

UPPER RESPIRATORY TRACT
Pharyngitis/Tonsillitis caused by *Streptococcus pyogenes*.
NOTE: The usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever, is penicillin given by the intramuscular route. Cefprozil is generally effective in the eradication of *Streptococcus pyogenes* from the nasopharynx; however, substantial data establishing the efficacy of cefprozil in the subsequent prevention of rheumatic fever are not available at present.
Otitis Media caused by *Streptococcus pneumoniae, Haemophilus influenzae*, and *Moraxella (Branhamella) catarrhalis*. (See CLINICAL STUDIES section.)
NOTE: In the treatment of otitis media due to beta-lactamase producing organisms, cefprozil had bacteriologic eradication rates somewhat lower than those observed with a product containing a specific beta-lactamase inhibitor. In considering the use of cefprozil, lower overall eradication rates should be balanced against the susceptibility patterns of the common microbes in a given geographic area and the increased potential for toxicity with products containing beta-lactamase inhibitors.

LOWER RESPIRATORY TRACT
Secondary Bacterial Infection of Acute Bronchitis and Acute Bacterial Exacerbation of Chronic Bronchitis caused by *Streptococcus pneumoniae, Haemophilus influenzae* (beta-lactamase positive and negative strains), and *Moraxella (Branhamella) catarrhalis*.

SKIN AND SKIN STRUCTURE
Uncomplicated Skin and Skin-Structure Infections caused by *Staphylococcus aureus* (including penicillinase-producing strains) and *Streptococcus pyogenes*. Abscesses usually require surgical drainage.
Culture and susceptibility testing should be performed when appropriate to determine susceptibility of the causative organism to cefprozil.

CONTRAINDICATIONS
CEFZIL is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS
BEFORE THERAPY WITH CEFZIL IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEFZIL, CEPHALOSPORINS, PENICILLINS, OR OTHER DRUGS. IF THIS PRODUCT IS TO BE GIVEN TO PENICILLIN-SENSITIVE PATIENTS, CAUTION SHOULD BE EXERCISED BECAUSE CROSS-SENSITIVITY AMONG BETA-LACTAM ANTIBIOTICS HAS BEEN CLEARLY DOCUMENTED AND MAY OCCUR IN UP TO 10% OF PATIENTS WITH A HISTORY OF PENICILLIN ALLERGY. IF AN ALLERGIC REACTION TO CEFZIL OCCURS, DISCONTINUE THE DRUG. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE TREATMENT WITH EPINEPHRINE AND OTHER EMERGENCY MEASURES, INCLUDING OXYGEN, INTRAVENOUS FLUIDS, INTRAVENOUS ANTIHISTAMINES, CORTICOSTEROIDS, PRESSOR AMINES, AND AIRWAY MANAGEMENT, AS CLINICALLY INDICATED.
Pseudomembranous colitis has been reported with nearly all antibacterial agents, and may range from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.
Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis."
After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibacterial drug effective against *Clostridium difficile*.

PRECAUTIONS
General
Evaluation of renal status before and during therapy is recommended, especially in seriously ill patients. In patients with known or suspected renal impairment (see DOSAGE AND ADMINISTRATION), careful clinical observation and appropriate laboratory studies should be done prior to and during therapy. The total daily dose of CEFZIL® (cefprozil) should be reduced in these patients because high and/or prolonged plasma antibiotic concentrations can occur in such individuals from usual doses. Cephalosporins, including CEFZIL, should be given with caution to patients receiving concurrent treatment with potent diuretics since these agents are suspected of adversely affecting renal function.
Prolonged use of CEFZIL may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Cefprozil should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Positive direct Coombs' tests have been reported during treatment with cephalosporin antibiotics.

Information for Patients
Phenylketonurics: CEFZIL for oral suspension contains phenylalanine 28 mg per 5 mL (1 teaspoonful) constituted suspension for both the 125 mg/5 mL and 250 mg/5 mL dosage forms.

Drug Interactions
Nephrotoxicity has been reported following concomitant administration of aminoglycoside antibiotics and cephalosporin antibiotics. Concomitant administration of probenecid doubled the AUC for cefprozil.

Drug/Laboratory Test Interactions
Cephalosporin antibiotics may produce a false-positive reaction for glucose in the urine with copper reduction tests (Benedict's or Fehling's solution or with Clinitest®[1] tablets), but not with enzyme-based tests for glycosuria (e.g., Tes-Tape®[2]). A false-negative reaction may occur in the ferricyanide test for blood glucose. The presence of cefprozil in the blood does not interfere with the assay of plasma or urine creatinine by the alkaline picrate method.

Carcinogenesis, Mutagenesis, and Impairment of Fertility
No mutagenic potential of cefprozil was found in appropriate prokaryotic or eukaryotic cells *in vitro* or *in vivo*. No *in vivo* long-term studies have been performed to evaluate carcinogenic potential.
Reproductive studies revealed no impairment of fertility in animals.

Pregnancy: Teratogenic Effects. Pregnancy Category B
Reproduction studies have been performed in mice, rats, and rabbits at doses 14, 7, and 0.7 times the maximum daily human dose (1000 mg) based upon mg/m^2, and have revealed no evidence of harm to the fetus due to cefprozil. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Labor and Delivery
Cefprozil has not been studied for use during labor and delivery. Treatment should only be given if clearly needed.

Nursing Mothers
It is not known whether cefprozil is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when CEFZIL is administered to a nursing mother.

Pediatric Use
Safety and effectiveness in pediatric patients below the age of 6 months have not been established. However, accumulation of other cephalosporin antibiotics in newborn infants (resulting from prolonged drug half-life in this age group) has been reported.

Geriatric Use
Healthy geriatric volunteers (≥ 65 years old) who received a single 1 g dose of cefprozil had 35%-60% higher AUC and 40% lower renal clearance values when compared to healthy adult volunteers 20-40 years of age. In clinical studies, when geriatric patients received the usual recommended adult doses, clinical efficacy and safety were acceptable and comparable to results in non-geriatric adult patients.

ADVERSE REACTIONS
The adverse reactions to cefprozil are similar to those observed with other orally administered cephalosporins. Cefprozil was usually well tolerated in controlled clinical trials. Approximately 2% of patients discontinued cefprozil therapy due to adverse events.
The most common adverse effects observed in patients treated with cefprozil are:
Gastrointestinal — Diarrhea (2.9%), nausea (3.5%), vomiting (1%), and abdominal pain (1%).
Hepatobiliary — Elevations of AST (SGOT) (2%), ALT (SGPT) (2%), alkaline phosphatase (0.2%), and bilirubin values (< 0.1 %). As with some penicillins and some other cephalosporin antibiotics, cholestatic jaundice has been reported rarely.
Hypersensitivity — Rash (0.9%), urticaria (0.1%). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy.
CNS — Dizziness (1%). Hyperactivity, headache, nervousness, insomnia, confusion, and somnolence have been reported rarely (< 1%). All were reversible.
Hematopoietic — Decreased leukocyte count (0.2%), eosinophilia (2.3%).
Renal — Elevated BUN (0.1%), serum creatinine (0.1%).
Other — Diaper rash and superinfection (1.5%), genital pruritus and vaginitis (1.6%).
The following adverse events, regardless of established causal relationship to CEFZIL, have been rarely reported during post-marketing surveillance: anaphylaxis, colitis (including pseudomembranous colitis), erythema multiforme, fever, serum-sickness like reactions, Stevens-Johnson Syndrome and thrombocytopenia.

Cephalosporin-class paragraph
In addition to the adverse reactions listed above which have been observed in patients treated with cefprozil, the following adverse reactions and altered laboratory tests have been reported for cephalosporin-class antibiotics:
Aplastic anemia, hemolytic anemia, hemorrhage, renal dysfunction, toxic epidermal necrolysis, toxic nephropathy, prolonged prothrombin time, positive Coombs' test, elevated LDH, pancytopenia, neutropenia, agranulocytosis.
Several cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment, when the dosage was not reduced. (See DOSAGE AND ADMINISTRATION and OVERDOSAGE.) If seizures associated with drug therapy occur, the drug should be discontinued. Anticonvulsant therapy can be given if clinically indicated.

OVERDOSAGE
Cefprozil is eliminated primarily by the kidneys. In case of severe overdosage, especially in patients with compromised renal function, hemodialysis will aid in the removal of cefprozil from the body.

CLINICAL STUDIES
Study One:
In a controlled clinical study of **acute otitis media** performed in the United States where significant rates of beta-lactamase producing organisms were found, cefprozil was compared to an oral antimicrobial agent that contained a specific beta-lactamase inhibitor. In this study, using very strict evaluability criteria and microbiologic and clinical response criteria at the 10-16 days post-therapy follow-up, the following presumptive bacterial eradication/clinical cure outcomes (*i.e.*, clinical success) and safety results were obtained:

U.S. Acute Otitis Media Study
Cetprozil vs. beta-lactamase inhibitor-containing control drug

Efficacy: Pathogen	% of Cases with Pathogen	Outcome
	(n = 155)	
S. pneumoniae	48.4%	cefprozil success rate 5% better than control
H. influenzae	35.5%	cefprozil success rate 17% less than control
M. catarrhalis	13.5%	cefprozil success rate 12% less than control
S. pyogenes	2.6%	cefprozil equivalent to control
Overall	100.0%	cefprozil success rate 5% less than control

Safety:
The incidence of adverse events, primarily diarrhea and rash,* were clinically and statistically significantly higher in the control arm versus the cefprozil arm.

Age Group	Cefprozil	Control
6 months – 2 years	21%	41%
3 – 12 years	10%	19%

* The majority of these involved the diaper area in young children.

Study Two:
In a controlled clinical study of **acute otitis media** performed in Europe, cefprozil was compared to an oral antimicrobial agent that contained a specific beta-lactamase inhibitor. As expected in a European population, this study had a lower incidence of beta-lactamase-producing organisms than usually seen in U.S. trials. In this study, using very strict evaluability criteria and microbiologic and clinical response criteria at the 10-16 days post-therapy follow-up, the following presumptive bacterial eradication/clinical cure outcomes (i.e., clinical success) were obtained:

European Acute Otitis Media Study
Cetprozil vs. beta-lactamase inhibitor-containing control drug

Efficacy: Pathogen	% of Cases with Pathogen	Outcome
	(n = 47)	
S. pneumoniae	51.0%	cefprozil equivalent to control
H. influenzae	29.8%	cefprozil equivalent to control
M. catarrhalis	6.4%	cefprozil equivalent to control
S. pyogenes	12.8%	cefprozil equivalent to control
Overall	100.0%	cefprozil equivalent to control

Safety:
The incidence of adverse events in the cefprozil arm was comparable to the incidence of adverse events in the control arm (agent that contained a specific beta-lactamase inhibitor).

REFERENCES
1. Clinitest® is a registered trademark of Miles Laboratories, Inc.
2. Tes-Tape® is a registered trademark of Eli Lilly and Company.

Revised June 1995
7718DIM-06

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commonly used as empiric anaerobic coverage when treating soft tissue infections, but it is important to note the invariable resistance of *E. corrodens* to these antimicrobial agents.

A study from Cook County Hospital in Chicago of 59 upper extremity abscesses associated with injection drug use estimated that 25% of these infections contained *E. corrodens.* It was the third most common organism isolated after staphylococcal and streptococcal species (8). Empiric antibiotic therapy against *E. corrodens* was suggested by these authors. Interestingly, many of the patients in this study admitted to licking their needles before injecting drugs with them, and another report by Angus reported almost 75% of one group of injection drug users used saliva in some manner in the drug injection process (9). We postulate that our patient's saliva used in the drug injection process was the source of the *Eikenella* and the *Peptostreptococcus*, whereas the *Proprionibacterium* most likely originated from the surface of his skin.

Data obtained through a chart review at West Virginia University Hospitals from October 1989 through October 1994 revealed that there were 49 isolates of *E. corrodens* from 35 different patients (Table 1). The average time to identify the organism grown in cultures was 8.6 days. Most often these isolates were part of a mixed infection (45 of 49 isolates, or 92%), and most were surgical specimens or related to surgical complications (42 of 49 isolates, or 86%). There was only one clench-fist injury and one soft tissue abscess related to injection drug use. We expect that *E. corrodens* infections may become more common in West Virginia if the population of injection drug users increases.

Conclusions

E. corrodens is a common gram negative anaerobic bacterium isolated in the injection drug use population. Unlike many other anaerobes, it is important to emphasize that clindamycin and metronidazole are ineffective against *E. corrodens*; and that penicillin is the drug of choice.

At least one study suggests empiric coverage for *E. corrodens* soft tissue infections in the injection drug use population. *E. corrodens* should be suspected if there is no clinical response to broad spectrum antibiotic therapy, or if saliva was used in the drug injecting process.

Table 1. *Eikenella corrodens* Isolates at WVU Hospitals 10/89 - 10/94

*49 total isolates identified

*45 of 49 (92%) were mixed infections

*42 of 49 (86%) were surgical specimens

*Mean time to grow and isolate was 8.6 days

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 6.1 or earlier versions or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black or pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Tracheostomy can make a difference in recurrent respiratory failure secondary to olivopontocerebellar atrophy

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Abstract

This article describes the case of a 55-year-old white male with olivopontocerebellar atrophy who was admitted to the ICU at Ohio Valley Medical Center because of recurrent respiratory failure. He had to remain in the ICU for 21 days on a ventilator even though he was hemodynamically stable with no evidence of pneumonia. A tracheostomy was then performed and within five days he was able to be weaned from the ventilator and transferred to a long-term care facility. This case suggests that early tracheostomy may play an important role in acute and long-term management in patients with olivopontocerebellar atrophy.

Introduction

Olivopontocerebellar atrophy (OPCA) is a chronic degenerative neurologic illness with complex and variable manifestations and controversial nosology. The most prominent and disabling element is usually pancerebellar, with dysarthria, nystagmus, ataxia, and hypotonus. Some patients develop Parkinsonian signs with bradykinesia, rigidity, masked facies, and other signs. All are usually poorly responsive to levodopa. The majority of cases occur sporadically, but when OPCA is inherited, by far the most common mode of transmission is autosomal dominance (1).

Patients with OPCA have nocturnal stridor, upper airway muscle weakness, and vocal cord dyskinesia. The disturbance of bilateral vocal cord abduction and the involuntary movements of vocal cords have been observed bronchoscopically. Electromyography has shown dyskinesia of the internal laryngeal muscles, but not paralysis. These results suggest that dyskinesia of the vocal cords is complicated in OPCA (3).

There are few reports of sleep apnea in patients with OPCA. References have been made to patients with neurologic deficits who have had respiratory failure and died in their sleep or required assisted ventilation at night. Sleep apnea may be an overlooked cause of respiratory complaints in neurologic patients, and nocturnal polysomnography (PSG) can provide a definitive diagnosis. Symptomatic obstructive sleep apnea, documented with nocturnal PSG, has also been reported in patients with posterior fossa lesions including OPCA and syringobulbia (5).

Patients with Parkinson's disease and other extrapyramidal disorders have been reported to have upper airway dysfunction, identified by abnormal maximum inspiratory and expiratory flow volume loops with an ocillation pattern referred to as "saw tooth." It has been reported that some patients with OPCA and respiratory dysfunction have responded to treatment with carbidopa-levodopa (2,4). However, most of the reported cases recommend tracheostomy to prevent sudden death secondary to vocal cord dysfunction (3,5).

Case report

A 55-year-old white male with OPCA was admitted for the second time to the ICU at Ohio Valley Medical Center on April 26, 1995, because of hypercapnic hypoxemic respiratory failure. He was intubated and placed on a mechanical ventilator.

His history revealed he had required prolonged mechanical ventilation during his previous admission to the ICU for the treatment of pneumonia and respiratory failure. He now showed no evidence of pneumonia and remained hemodynamically stable, but he could not be weaned from the ventilator.

After 21 days, a tracheostomy was performed, and five days later the ventilator parameters and arterial blood gases demonstrated marked improvement (Tables 1,2) so he was weaned from the machine. He progressed well and was transferred to a long-term care facility.

Currently, the patient is able to speak through a talking tracheostomy and has not required further assisted ventilation, even during a subsequent hospital admission for pneumonia.

Discussion

OPCA is included in Multiple Systemic Atrophy (MSA) which was described by Graham and Oppenheimer and Bannister and Oppenheimer on the bases of neuropathologic studies (6,7). MSA causes degeneration of the cerebellar, extrapyramidal, and autonomic systems. OPCA starts with cerebellar ataxia and extrapyramidal signs, but few autonomic signs. MRI findings show atrophies of the pontine base and cerebellar cortex with dilatation of the fourth ventricle (3,7).

Our patient had recurrent respiratory failure which probably related to his nocturnal stridor, vocal cord dysfunctions, and sleep apnea. Although he received a trial in the past of levodopa, his disease was worsening, and he became more symptomatic. By the time we finally saw him, he was having slurred speech, stridor, and dyspnea. Despite our conservative management, it was difficult for us to wean him from the ventilator. If this patient had been left untreated, he would have been prone to infection. For this reason, a tracheostomy was performed so the physiologic dead space could be bypassed and it would be easier to wean him from the ventilator.

The Aragane study reported a case of OPCA in which a patient who had vocal cord dyskinesia, stridor, and internal laryngeal dysfunction proved by bronchoscopy and electromyogram underwent a tracheostomy and had a successful recovery (3). The Adelman study reported another case of a patient with Parkinson's disease and extrapyramidal symptoms who underwent tracheostomy to improve his condition (5). In 1979, the Bannister study described three patients with Shy-Dragger Syndrome

Table 1. Ventilatory Weaning Parameters

Index	Pre-tracheostomy	Post-tracheostomy
Tidal Volume	250	368
Minute Ventilation	5.2	8.1
Respiratory Rate	30	22
Negative Inspiratory Force	-38	-60
Rapid Shallow Breathing Index	120	59.8

Table 2. Arterial Blood Gases

Index	Admission	Pre-tracheostomy	Post-tracheostomy	Discharge
O2	100%	800, .4, 10IMV,10PS	800, .4, 10IMV, 10PS	40%, 10PS
pH	7.23	7.44	7.44	7.42
pCO2	107	44.1	42.7	41.2
pO2	58.9	74.7	88.4	98.9
O2 Sat	83.9	95.3	97.0	97.6

who had severe laryngeal stridor that required tracheostomy for relief of their symptoms (6).

From the case reports of Schiffman and Golbe as well as Vicken and colleagues, an initial treatment of carbidopa levodopa should be instituted in any patient with OPCA who has respiratory symptoms (1,2). Our patient was treated at admission with levodopa, but still displayed respiratory symptoms with recurrence of respiratory failure. When this occurs, tracheostomy is indicated as the treatment of choice.

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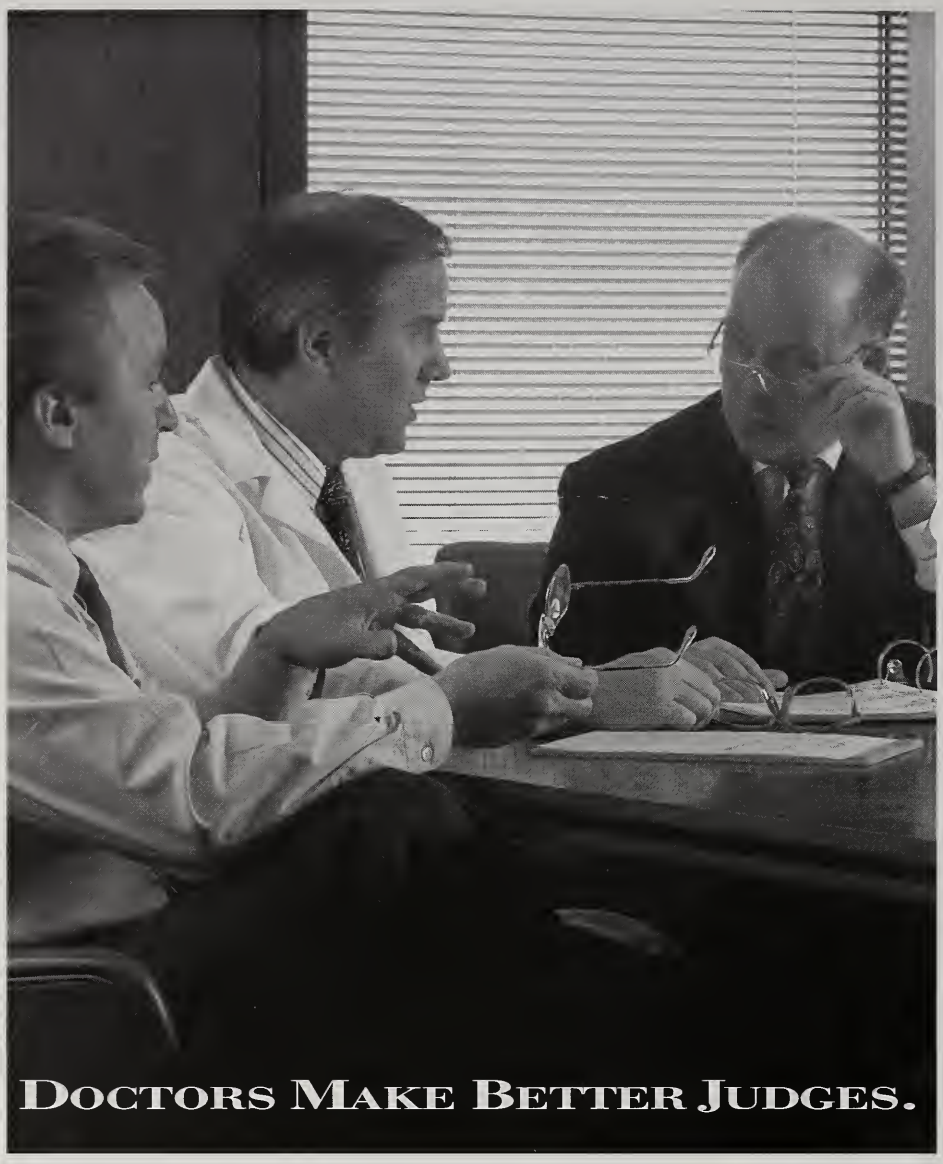

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This seminar is provided at no charge to attendees.

9:30	-	9:45	Arrival and Registration
9:45	-	10:00	Opening Remarks and Introductions
10:00	-	11:00	**Health Care Finance**
11:00	-	11:30	**Business Valuations of Health Care Entities**
11:30	-	12:00	**Reimbursement Update**
12:00	-	1:00	Lunch (Buffet Provided)
1:00	-	1:30	**Records Disclosure - Are Your Release Forms Adequate?**
1:30	-	2:00	**How to Minimize Hospital/Physician Liability for COBRA Violations**
2:00	-	2:30	**Fraud and Abuse Compliance Audits**
2:30	-	3:00	**Mergers, Acquisitions and Reorganizations - Anti-Trust Guidelines**
3:00	-	3:30	**1996 Legislative Update - Impact on Health Care Providers**
3:30	-	3:45	Break
3:45	-	4:15	**The Benefits and Protections of Reporting and Disclosure Policies**
4:15	-	4:45	**Medical Waste Disposal Issues**
4:45	-	5:15	**An Acquisition Case Study**
5:15	-	5:30	Concluding Remarks and Reception

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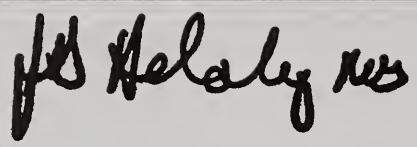
President's Page



Defensive medicine

When I hear anyone speaking in public or stating on television that there is no such thing as defensive medicine, that it doesn't exist, I am appalled! The people who make these statements about the profession are usually not physicians and, to my knowledge, never physicians who have actually practiced the art.

I suspect that those who quote research that indicates an absence of defensive medicine are making their assertions based on unproven theories, loosely stitched together to reach a conclusion which suits their needs. Trial attorneys are the most vocal examples of these individuals. They always seem to defend the assertion that there is a perfectly functioning medical tort reform system in the U.S.

I suppose that if one says something over and over in repetition long enough, he/she might begin to believe it. I challenge any member of the WVSMA to produce irrefutable, confirmed scientific results indicating that defensive medicine does not exist.

I know, as each of you do, that defensive medicine is a part of our daily practice. It continually occupies our thoughts when we write orders on a patient's chart or dictate notes about a case; as well as when we order tests, make any type of diagnosis, or consult with another physician. In addition, many of us at sometime in our careers have had to endure the painful and devastating effects of a lawsuit. As a result, defensive medicine has become a driving force to increase costs.

IF THERE WASN'T A NEED TO PRACTICE DEFENSIVE MEDICINE, COULD COSTS BE CONTROLLED SO THAT THERE WOULD NEVER BE A NEED FOR MANAGED CARE?

Many times I'm sure you have heard trial attorneys make the statement that they are the protectors of the people's rights. Often they try to stir emotions by claiming themselves the last and only hope of the unsuspecting who have been wantonly injured by the reckless, intentional disregard of mean-spirited doctors!

Let's assume that we physicians, who spend 1/3 of our lives preparing to practice medicine to heal the sick and injured, endorse the sole purpose of carrying out cold-blooded negligence. It's absurd, but let's assume it anyway.

If indeed the trial attorneys are the champions of those innocently harmed, wouldn't it stand to reason that they would endorse the concept of limited contingency fees? Wouldn't they want their poor, injured clients to receive more of the settlement awards?

Yet, the trial attorneys vehemently fight any attempt to limit their contingency fees - - those very fees coming out of the settlement AFTER all other legal expenses have been deducted! Many times the client receives half, or less than half of the malpractice award.

If trial attorneys were truly interested in the welfare of their clients, wouldn't they want their clients to receive more of the award? GO FIGURE!!!

James D. Helsley, M.D.

Caveat Emptor

Managed Care, an incoming tide swelling against the welcoming shores of human sickness, disease, injury, life and, even, death ... a tsunami!

Managed Care, a path heralded by edenic billboards displaying lush gardens, waterfalls, swaying palm trees and bright sunshine ... leading straight into the desert.

It certainly does seem like a hopeless and futile exercise to rail against something as apparently inevitable as Managed Care. What makes things even more difficult in our railing against Managed Care is that we have had a form of managed care ever since we have had doctors and something called the practice of medicine. The big difference between upper case Managed Care and lower case managed care is who is to be the beneficiary of the managed care system. A second major difference is who does the managing.

Traditionally, it has been clear that the patient was to be the recipient of any benefits to be derived from the doctor's advice and recommendations. Dollars were rarely if ever mentioned. That is no longer the case. Under Managed Care it is now perfectly clear that some fund of money is to be the recipient of any benefits to be derived from the "managing." The ease, comfort, health and even longevity of the patient are strictly secondary matters. The primary concerns are that the fund of money remains in the black, and that the company or the fund be profitable.

Of course, traditionally, it has been the doctor in consultation with the patient doing the managing. With Managed Care it is some nameless, faceless voice at the end of a long distance telephone line totally unfamiliar with the patient or the doctor, totally ignorant of the pain, anguish, fortitude or lack of such, totally ignorant of the idiosyncrasies, community standards and expectations, who must make decisions about the patient's care while sitting with only a statistical chart for reference. If continued employment is expected or valued in anyway, these decisions are made invariably in favor of the company or the fund of money.

There never has been anything wrong with managed care. It is the dishonesty and lies of those who merchandise Managed Care that is wrong and reprehensible. The sales pitches are fraudulent. Patients, clients, subscribers and customers (or whatever term is applied to the gulled public), are led to believe they will receive far more benefits than are ever intended to be given. They are not told what they will not be getting. Any Better Business Bureau would quickly indict a merchant using similar sales tactics.

Buyer beware is, without question, an appropriate warning for our patients who are required to make a choice among a variety of medical care plans. A similar warning is not unreasonable for doctors considering involvement with Managed Care.

Stephen D. Ward, M.D.
Editor

Letter to the Editor

Doug Milner, a freelance photographer and former *Dallas Times Herald* staffer, died recently due to an allergic reaction to a wasp sting. His death and the deaths of thousands of other individuals, have been needless because they are the result of a lack of education and legislation concerning the use of epinephrine (adrenaline) which is used in the case of an anaphylactic reaction to an insect sting.

I have worked to educate the public about the use of epinephrine and to get laws passed in states so laymen will be able to administer it. As a lone crusader, I have been able to get legislation passed in 20 states. Texas, where Mr. Milner lived, is not one of these states.

Everyone should have an emergency epinephrine kit. Death from a severe anaphylactic reaction can occur in five minutes, which is insufficient time to get to medical aid. Doug Milner was unconscious within minutes.

Epinephrine (adrenaline) is the only treatment that will save a person suffering an anaphylactic reaction.

Claude A. Frazier, M.D.
Ashville, N.C.

Intercepted Communications

Health 'reform' still big concern

Editor's Note: This letter appeared in* The Parkersburg News *and we are reprinting it with the author's permission.

"We're going to push through health care reform, regardless of the views of the American people." This quote from U.S. Sen. Jay Rockefeller who represents West Virginia has been published in various newspapers. Has Rockefeller made good on his boast?

What *is* happening to our health care system? Many citizens note substantial changes in the delivery of their health care. The numbers of home health care providers, visiting nurses, elder care facilities, hospices, etc. have increased dramatically. What are the qualifications for home care providers or for those employed by the new *facilities?* How well trained are these persons to whom we entrust the medical care of ourselves and our loved ones? Do they have adequate education and training necessary to make knowledgeable assessments of our physical (or mental) conditions?

Health Management Organizations are now epidemic. They are reputed to be more cost effective. Are they health effective? Recent media reports have stated that primary care providers are given financial incentives to keep costs down. Would all primary care doctors sanction a referral to another doctor for a second opinion should the patient request a second opinion?

Recent reports of some HMOs state that the emphasis will be maintenance of health rather than medical care. If the citizens are to accept the responsibility of maintaining their health, will there be a corresponding reduction in the cost of health insurance to those citizens or will working taxpayers continue to pay more for less?

A section ("Health Sciences") of the "West Virginia Higher Education Report Card 1992" contains 123 pages of information, including the Status Report of "The Caperton Plan" ... The Rural Health Initiative Act of 1991. Where do the Health and Wellness Centers located in our public schools fit into this program?

Is this the health care reform to which Sen. Rockefeller referred? Was the storm of controversy concerning the Hillary Clinton health care reform plan, in fact, much ado about nothing? Was the basis for health care reform contained in the education reform legislation — the highly controversial Goals 2000? Has the long arm of the federal government seized control of our education *and* our health care?

The 1992 Status Report of the Rural Health Initiative lists the lead agencies with an accompanying map of their locations on page 254. Ritchie and Calhoun counties comprise the Minnie Hamilton Health Care Consortium. I would wager that the vast majority of Ritchie County citizens have never heard of the Minnie Hamilton Health Care Consortium. A recent news item reported the possibility of the purchase of the Calhoun General Hospital by the Minnie Hamilton Health Care Center.

Page 267 of the aforementioned report gives information on this Rural Health Care Education Site: "Brief Description: The Minnie Hamilton Health Care Consortium consists of one primary care center, one hospital, two county health departments and two private practitioners, serving Ritchie and Calhoun counties."

Can this be the health care reform to which Rockefeller referred?

West Virginia citizens need to evaluate the direction of health care reform within the state and to insist that the quality of their medical care and their right to their choice of doctors is not infringed.

Sincerely,

MARGARET C. GLASS
Pennsboro

ASK ANY DOCTOR, NEGLECTING A SERIOUS HEALTH PROBLEM WILL ONLY MAKE IT WORSE.

Whether it's a distressed kidney or a distressed health care system, the diagnosis is trouble unless the problem is treated properly. That's why we need to act on legislation that's already in Congress. We've heard the experts and we've heard the debates. Now you need to let your vote do the talking. So we'd like to remind you what our professional opinion is. The 300,000 physician members of the American Medical Association urge Congress and the Administration to approve the following reforms for the good health of our patients and the good health of the country.

Health Insurance Market Reforms: We need to expand health insurance coverage by removing current restrictions on pre-existing conditions and end "job-lock" by guaranteeing portability as provided in S. 1028, the Kassebaum-Kennedy bill.

Antitrust Relief for Physician Sponsored Networks: We should promote greater choice and competition through local physician networks by passage of antitrust relief as contained in H.R. 2925.

Patient Protections: Patients need better information and basic fairness safeguards in today's health insurance market. Gag clauses that attempt to restrict physician-patient discussion of treatment options should be prohibited. If mothers and newborns need to stay an extra day, they should be protected from premature hospital discharges.

Medical Liability Reforms: Americans are paying too high a price for the excesses of our legal system. The House of Representatives passed the California model of balanced medical liability twice last year.

Regulatory Relief: We need to cut red tape by reforming physician office lab requirements and adopting widely supported changes in the so-called "Stark I and II" physician referral laws.

Medicare Reform: Recent reports indicate we are closer to an insolvency of the Medicare program than we previously thought. The Balanced Budget Act of 1995 contained critical reforms that would preserve the Medicare program for current and future generations. We need to enact these reforms while we still have the time.

Medicaid Reforms: Both the Congress and the Administration need to strike a balance between greater state flexibility and assuring continued coverage for our nation's most vulnerable populations.

American Medical Association

Physicians dedicated to the health of America

Book Reviews

Vandals at the Gates of Medicine: Historic Perspectives on the Battle Over Health Care Reform

By Miguel A. Faria Jr., M.D.

The best information that life affords about the future is found in the past (1). Unfortunately, most historians have abandoned the outdated idea that history has lessons.

Not so with Dr. Miguel Faria, who is professor of neurosurgery and an adjunct professor of medical history at Mercer University School of Medicine, and is editor-in-chief of *The Medical Sentinel* of the Association of American Physicians and Surgeons. By combining astute political insight with his encyclopedic knowledge of history, he creates a unique blend of historical perspective and political commentary, with emphasis on the development of medicine and medical ethics.

This book has 32 chapters divided into the following seven sections: Antiquity, Greece, Rome, Graeco-Roman Medicine, Graeco-Roman Medical Ethics and Intimations for the Present, Middle Ages, and The Renaissance. It traces the history of medical ethics back to the 8th Century B.C., with contributions from Homer's *"The Iliad,"* Herodotus' *"Accounts of the Persian Wars,"* the Pythagorean Principles, and the Corpus Hippocraticum. The oldest ethical theory presented is virtue-based and emphasizes the professional individuality of the physician rather than the resolution of every complex ethical dilemma. The humanity of both the physician and the patient is explored in depth, and the special relationship which binds the two. This relationship depends largely on the character, trustworthiness, moral sensitivity and resources of the physician, where the physician serves beyond self-interest (2).

The book then describes how this rich ethical heritage has been lost, as has our priceless dual legacy of Graeco-Roman humanism and Judeo-Christian culture. Today, we face many of the same problems that preceded the decline and fall of the Roman Empire - - class warfare, misguided economic policies, increased central bureaucracy, and numerous government subsidies and entitlements. Other prime examples are the use of practice parameters to limit treatment for the sake of cost reductions, the indiscrimate collection of data to evaluate cost-effectiveness of care, and the use of dubious clinical outcomes to document patient satisfaction. This data collection will "give the state the power to call doctors 'guilty' whenever it likes," or "satisfy the bureaucrats in search of fulfillment of their goverment-assigned quotas of provider-victims" (3). In addition to all of these examples, the "litigation juggernaut" is an important threat to property, individual liberty, and our constitutional government itself. If not stopped, it will surely destroy the patient-doctor relationship (4).

In a unique chapter, the author reviews in some detail other problems which do not have clear parallels to those in the past, such as the Soviet Code of Medical Ethics, the Egalitarian Ethics of our legal profession (which has "made fortunes" for the litigators, {causing} the erosion of moral values and the corruption of ethics in the legal profession"), and the state socialism found in Cuba, Nicaragua, Great Britian, France, Canada, and the Netherlands (5).

Medicine today is criticized by health care "experts" who are "statist bureaucrats . . . {whose} prime motivation is simply camouflaged self-interest . . ." Also, many of our medical ethicists are not practicing physicians or even medical doctors, yet presume to know what is wrong with the practice of medicine (6).

Even worse, our citizens seek perpetual youth and perfect health without accepting the responsibility for their self-destructive behavior and unhealthy lifestyles, even though the responsibility of the patient to make his/her own health care decisions dates back to Graeco-Roman times.

The most important of all reasons to study the past is to attempt to foretell the future. The study of recorded history suggests that we should reject the "egalitarian socialist ethos of {our} entrenched political establishment" and instead adopt an objective philosophy which embraces enlightened self-interest, private charity, and individual responsibility (7). We should use Medical Savings Accounts to empower patients instead of government bureaucrats. This would correct our government-created, health-care problems without the use of rationing.

Vandals at the Gates of Medicine is one of the most important books on health care reform to be published in recent years. It is a priceless treasure of lessons hidden in our past. Its wealth of historical detail will be difficult for those with no interest in history, but it will appeal to all others, including health-care professionals, industry executives, health policy makers, politicians, and all citizens who would be better informed about today's health-care options.

Jerome C. Arnett Jr., M.D.
Elkins

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2. Faria MA Jr. M.D. Vandals at the Gates of Medicine: Historic Perspectives on the Battle Over Health Care Reform. Hacienda Publishing, Macon, Ga., 1994:214.
3. Ibid, p. 226.
4. Ibid, p. 143.
5. Ibid, p. 240.
6. Ibid, p. 222.
7. Ibid, p. 224.

The Bell Curve: Intelligence and Class Structure in American Life

Richard J. Herrnstein and Charles Murray

Not since Masters and Johnson's publication of *Human Sexual Inadequacy* in 1970 has a non-fiction academic work loaded with statistics, graphs, footnotes and references become the kind of best-seller which *The Bell Curve* has been. The book is so controversial that Charles Murray, the book's only surviving author, is now a national celebrity who is constantly called upon to defend its methodology and conclusions.

Murray is a political scientist who is a fellow at the American Enterprise Institute, and his co-author Richard Herrnstein was the holder of the Edgar Pierce Chair in Psychology at Harvard University before his untimely death shortly before the book was published. They wrote this book to expose what they describe as the great transformation in American society which has produced a new class structure led by a "cognitive elite" (high I.Q. persons) who enjoy the best of what our society has to offer, and unfortunately, also includes its opposite a "cognitive underclass" fraught with poverty, crime, unemployment, and other serious social problems. As the authors put it in their preface: "This book is about differences in intellectual capacity among people and groups and what those differences mean for America's future." The authors were not devious in specifying which group differences they were concentrating on and state in a article they wrote for the *New Republic* that "The private dialogue about race in America is far different than the public one" (1).

The Bell Curve is not a book based on original research, but a carefully written review of the literature on intelligence, class, and interrelated subjects from a rather narrowly defined point of view. The most provacative conclusion of the book is that I.Q. is largely genetically determined and relatively immutable. A suggestion is made that since blacks consistently score 15 points below whites on standard I.Q. tests and form a very large proportion of the cognitive underclass, they are genetically and unalterably inferior to whites. As a result of this, the authors state that various programs designed to help blacks such as Affirmative Action, welfare, etc. are a waste of the taxpayer's money.

Since the authors seem to directly and indirectly pay homage to biological determinists such as A. R. Jensen, J. P. Ruston, W. Shockley, and R. Lynn, the black community has shown some concern about the consequences of their work on the black underclass and blacks in general. Blacks have been especially worried about the work of Lynn who has published often in the *Mankind Quarterly,* a neo-eugenist journal edited by Roger Pearson. Recently, Pearson stated that "If a nation with a more advanced, more specialized or in anyway superior set of genes mingles with, instead of exterminating, an inferior tribe, then it commits racial suicide." These words sound very much like those uttered and written by a moustached former Viennese paperhanger who regarded Jews as an "inferior tribe" (2).

As a behavioral scientist and research methodologist, I am concerned with the theory promoted by Herrnstein and Murray, and the data they present to support it. The author's significant assertion is that there is "general intelligence" (Spearman's g), which is measurable by standardized I.Q. tests. They claim there is general consensus among experts that g exists, but the reality is that there is much disagreement on this issue. There are at least two other major views on the nature of intelligence which Herrnstein and Murray largely ignored, namely, the multidimensional theories of Gardner (3) and Sternberg (4) and the contingent/contextual theory of Lave (5).

Thus far, there is no empirical basis for demonstrating the existence of g. All the so-called supporting data are indirect measures and the inferences made from those measures may properly go in directions not supporting the idea of g. The authors attribute as much as 60% of g to heredity. They seem unaware of the literature in the neurosciences that shows there is a significant connection between the brain and environmental factors. Depending on the changing characteristics of the environment, even one neuron may manifest several different patterns of behavior (6). It is, thus, irresponsible on their part to assign any figure on the impact of genetics on g.

The Bell Curve's conclusions should also be questioned due to the methodology connected with I.Q. test construction and scoring, as well as the statistics used on I.Q. tests as they relate to other behavioral science tests. Most behavioral science tests, including I.Q. tests, are at best ordinal scales that can only roughly and crudely sort people on the trait of intelligence. Yet, Herrnstein and Murray, deal with the variable intelligence as if it were a continuous rather than as a discrete variable.

I am also deeply troubled about the misuse and abuse of the term race in *The Bell Curve.* In the early 1950s, leading experts on race put out two statements, sponsored by UNESCO, which suggest that race was a tired and misleading concept which would best be abolished in favor of the term ethnic group (7,8).

The Bell Curve, in spite of its many faults and almost 900 pages, is a valuable work because it forces us to really think about the nature of intelligence, the matter of intelligence testing, and what intelligence means in our lives.

Robert M. Frumkin, Ph.D., F.A.A.A.S.
Salem

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At Annual Meeting

Harris, Flink Addresses to focus on graduate surgical education, proper use of antibiotics

The Thomas L. Harris Address at this year's WVSMA Annual Meeting will be presented by **Gordon F. Murray, M.D.**, chairman of the Department of Surgery at the Robert C. Byrd Health Sciences Center of WVU in Morgantown. Dr. Murray's lecture, *"Graduate Surgical Education - At Risk,"* will be presented at 9 a.m. on Friday, August 23 during the First Session of the House of Delegates.

The following day at 10:15 a.m. during the Second Session of the WVSMA House of Delegates, **Joseph H. Talley, M.D.**, a family practitioner from Shelby, N.C., will deliver the Edmund B. Flink Address on *"Bugs and Drugs: An Antibiotic Selection Overview."* CME is being offered for both this address and the T. L. Harris Address.

In addition to the Thomas L. Harris Address, Dr. Murray will lecture on the subject of *"Marfan's Syndrome"* for the General Scientific Session on Thursday, August 22 at 9 a.m., and Dr. Talley will also be making another presentation entitled *"Treatment with Controlled Substances - - How to Keep Your License,"* for a Lunch and Learn which will take place on on Friday, August 23 at noon.

Brief biographical information about these two speakers begins below. A registration form for this year's meeting appears on page 155, and more details about the convention can be obtained by phoning the WVSMA at (304) 925-0342.

Speakers highlighted

Dr. Murray was born in Muskegon, Mich., and received his M.D. from the University of Michigan in 1963. He completed residencies in general and thoracic surgery at Massachusetts General Hospital and Johns Hopkins Hospital.

A commander in the U.S. Naval Reserve, Dr. Murray served at the U.S. Naval Hospital in Great Lakes, Ill. His academic experiences include positions as professor and associate chief of thoracic surgery in North Carolina Memorial Hospital in Chapel Hill, N.C., from 1972-85, and his current posts as chairman of the Department of Surgery at the Robert C. Byrd Health Sciences Center of WVU in Morgantown and chief of surgical services at Ruby Memorial Hospital. In addition, Dr. Murray is currently the cardiac surgeon-in-charge at Monongalia General Hospital in Morgantown.

Murray

Board certified by the American Board of Surgery and The American Board of Thoracic Surgery, Dr. Murray has distinguished himself nationally as an academic surgeon. He is a past president of the Southern Thoracic Surgical Association and the Thoracic Surgery Directors Association, and is chairman of the Examination Committee of the American Board of Thoracic Surgery.

Dr. Talley was born in Burlington, N.C., and received his M.D. degree from the University of Virginia School of Medicine in 1963. Upon receiving his medical degree, he did a rotating internship in Norfolk General Hospital in Norfolk, Va.

From 1964-66, Dr. Talley served as a general medical officer in the U.S. Navy, and then he completed a general practice residency at Charlotte Memorial Hospital in Charlotte, N.C. He went into private practice in Greenville, S.C., for a year and then joined the ER staff at Greenville General Hospital.

In 1969, Dr. Talley left Greenville General to open a private practice in Grover, N.C. He practiced in Grover until 1975 when he returned to Charlotte Memorial Hospital to work on the faculty at the hospital's Family Practice Center and become a clinical assistant professor at the University of North Carolina in Chapel Hill, where he is still on the faculty. Two years later, Dr. Talley left Charlotte Memorial so he could go back to Grover, which has a population of 600, to reopen his family practice office.

Board certified in family practice, Dr. Talley is a past president of the Interstate Postgraduate Medical Association of North America. He travels extensively to present lectures on a variety of family medicine topics, and he has special interests in infectious disease, depressive and anxiety disorders, counseling and the treatment of snake and spider bites.

Don't Delay – Do It Today!

Register for the WVSMA's 129th Annual Meeting

Turn to page 155
or
Phone (304) 925-0342

1996 WVSMA Annual Meeting Highlights

August 21-24, 1996

Tuesday, August 20

6 p.m.	WVSMA Executive Committee Dinner/Business Meeting

Wednesday, August 21

9 a.m.	WVSMA Executive Committee Breakfast Meeting
noon - 1:30 p.m.	Executive Committee/Council Luncheon
1:30 - 4:30 p.m.	WVSMA Council Meeting
6:30 - 7:30 p.m.	Presidential Reception

Thursday, August 22

7 - 8:30 a.m.	Medical Education Committee Breakfast Meeting
9 a.m. - noon	**General Scientific Session** "Marfan's Syndrome" - Gordon F. Murray, MD "Interventional Cardiology: Promises Fulfilled?" - Kenneth M. Kent, MD "Office Evaluation of Children with Suspected Heart Disease" - William A. Neal, MD "Non-surgical Treatment of Heart Disease" - Stafford G. Warren, MD
noon - 1:30 p.m.	**Lunch and Learn** (limited space) "The Terminally Ill Patient: Is Physician-Assisted Death the Answer?" - Alvin H. Moss, MD AMA President and Other Visiting Dignitaries
2 p.m.	Golf, Tennis, and Volleyball Tournaments
4 p.m.	1997 Annual Program Committee Meeting
6:30 - 7:30 p.m.	Reception

Friday, August 23

7 a.m.	**Breakfast Meetings** (times and locations to be announced)
9:00 a.m.	**First Session of the House of Delegates** **Thomas L. Harris Address** - Gordon F. Murray, MD "Graduate Surgical Education - At Risk" WVSMA Presidential Address - James D. Helsley, MD
noon - 1:30 p.m.	**Lunch and Learn** (limited space) "Treatment with Controlled Substances -- How to Keep Your License" Joseph H. Talley, MD, AMA President and Other Visiting Dignitaries
noon	**Specialty Meetings** Various West Virginia Specialty Societies will be scheduled for luncheon/business and scientific meetings. Times and locations will be noted in the official program.
1:30 p.m.	Resolutions Committee - Open Session
6 - 7 p.m.	Reception hosted by WVU/MU Schools of Medicine
9:30 - 11 p.m.	Entertainment

Saturday, August 24

7:30 a.m.	**Breakfast Meetings** (times and locations to be announced)
9 a.m.	**Second Session of the WVSMA House of Delegates**
9:30 a.m.	AMA Presidential Address - Daniel H. Johnson Jr., MD Resolutions Election of Officers
10:15 - 11 a.m.	**E. B. Flink Address** - Joseph H. Talley, MD "Bugs & Drugs" An Antibiotic Selection Overview
noon - 1:30 p.m.	WVSMA Component and Specialty Society Presidents, Past Presidents, Visiting State Presidents and 50-Year Graduates Luncheon
1:30 p.m.	**Reconvene Second Session of the House of Delegates** (business continued) Oath of Office and Presidential Address
4 - 5 p.m.*	Reception Honoring Newly-Installed Officers of WVSMA and Alliance

**Time dependent upon adjournment of House of Delegates' Session*

Two CME Lunch and Learns set for Annual Meeting

Two of the popular Lunch and Learn CME events will be conducted during the WVSMA's Annual Meeting at The Greenbrier.

The first Lunch and Learn is entitled *"The Terminally-Ill Patient: Is Physician-Assisted Death the Answer?"* and will be presented on Thursday, August 22 at noon by Alvin H. Moss, M.D., director of the Center for Health Ethics and Law at the Robert C. Byrd Health Sciences Center of WVU. Dr. Moss will be joined by a panel of distinguished guests including AMA President Daniel H. *"Stormy"* Johnson Jr., and several state medical presidents.

The second Lunch and Learn is set for Friday, August 23 at noon and it will feature Joseph H. Talley, M.D., a family practitioner from Shelby, N.C., speaking on the subject of *"Treatment with Controlled Substances - - How to Keep Your License."* Dr. Talley will also be joined by Dr. Johnson and several state medical presidents for a panel discussion. In addition to this Lunch and Learn lecture, Dr. Talley will also deliver the Edmund B. Flink Address. *(See page 150).*

The cost for each Lunch and Learn is $50 for physicians, and $35 for spouses, medical students and all others. To register, complete the form on page 155 or phone the WVSMA at (304) 925-0342.

Moss

Johnson

Speakers highlighted

Dr. Moss is a practicing internist and nephrologist, who developed an interest in medical ethics as a result of his work in renal dialysis and transplantation. He is currently director of the Center for Health Ethics and Law at WVU, where he is also a professor of medicine and director of the Bioethics Program.

Dr. Moss has been a participant in the National Leadership Training Program for Physicians in Clinical Medical Ethics at the University of Chicago supported by the Pew Charitable Trusts and the Henry J. Kaiser Family Foundation. He serves as chairman of the Hospital Ethics Committee at WVU Hospitals and is the executive director of the West Virginia Network of Ethics Committees.

A member of the Guardianship Task Force of the West Virginia Department of Health and Human Resources, Dr. Moss chaired the committee that drafted the Health Care Surrogate Act of 1993 and the Do Not Resuscitate Act. His research interests include the use of life-sustaining treatment, advance care planning, and narrative ethics.

A noted speaker on medical ethics, Dr. Moss has given talks throughout the state on advance directives, health care decision making, cardiopulmonary resuscitation, do-not-resuscitate orders, responding to family requests for unreasonable treatment, and issues concerning the care of dying patients.

Dr. Talley was born in Burlington, N.C., and received his M.D. degree from the University of Virginia School of Medicine in 1963. He did an internship at Norfolk General Hospital in Norfolk, Va., and then served as a medical officer in the U. S. Navy from 1964-66.

After his military service, Dr. Talley completed a general practice residency at Charlotte Memorial Hospital in Charlotte, N.C. In 1967, he went into private practice in Greenville, S.C., for a year, and then joined the ER staff at Greenville General Hospital.

In 1969, Dr. Talley left Greenville General to open a private practice in Grover, N.C. He practiced in Grover until 1975 when he returned to Charlotte Memorial Hospital to work on the faculty at the hospital's Family Practice Center and become a clinical assistant professor at the University of North Carolina in Chapel Hill, where he is still on the faculty. Two years later, Dr. Talley left Charlotte Memorial so he could go back to Grover to reopen his family practice office.

Board certified in family practice, Dr. Talley is a past president of the Interstate Postgraduate Medical Association of North America. He presents lectures on a variety of family medicine topics, and he has special interests in infectious disease, depressive and anxiety disorders, counseling and the treatment of snake and spider bites.

Alliance to hold cooking demonstration, art auction to raise funds for AMA-ERF

During their Annual Meeting at The Greenbrier, the WVSMA Alliance has scheduled a cooking demonstration with one of The Greenbrier's chefs and they plan to have a silent art auction in order to raise funds for the American Medical Association Education and Research Foundation (AMA-ERF).

The Alliance's theme for their meeting is *"Christmas in August"* and the cooking demonstration will feature a variety of cookies and desserts for holiday entertaining. This presentation will take place during the President's Luncheon on Friday, August 23 at 12:30 p.m.

For the silent art auction, WVSMAA President Linda Elliott would like physicians and Alliance members to donate any items of art such as painting, sketches, sculpture, pottery, photographs, needlepoint, etc. These items will be placed on display and anyone may bid on them by making a written offer. The highest bidders for each piece of art will then be announced during the special evening of jazz music which will take place on Friday, August 22 from 9:30 p.m. - 11 p.m.

To donate items for the art auction or obtain more information about these events, contact Janie Altmeyer at 1-800-501-8447.

WVSMA offering CME site surveyor workshop on May 23

"CME into the Next Millennia: Wild and Wonderful" is the title of a site surveyor workshop which the WVSMA is conducting at the Robert C. Byrd Health Sciences Center of WVU in Charleston on Thursday, May 23.

This workshop will begin at 9 a.m. with registration in the lobby of the Robert C. Byrd Health Sciences Center. At 9:25 a.m., John W. Traubert, M.D., chairman of the WVSMA Committee on Medical Education, will deliver opening remarks. Immediately following, the keynote address will be given by Robert S. Pyatt, M.D., F.A.C.R.,who is CME/quality consultant for the Commission on CME of the Pennsylvania Medical Society.

Dr. Pyatt received his M.D. from the State University of New York at Syracuse in 1975. He completed a diversified internship and a diagnostic radiology residency at Bethesda Naval Hospital in Bethesda, Md.

After finishing his internship and residency, Dr. Pyatt remained at Bethesda to serve as co-chairman of the Visceral Imaging Section from 1979-81. In 1979, he also joined the faculty of George Washington University Medical Center in Washington, D. C., as a clinical assistant professor of radiology, a position he still holds today.

Dr. Pyatt relocated to Chambersburg, Pa., in 1982 to accept his one of his other current post as medical director of the Department of Diagnostic Imaging/Radiology at Chambersburg Hospital. Since 1986, Dr. Pyatt has also been a clinical assistant professor of radiology at Hershey Medical Center in Hershey, Pa., and chairman of the Department of Radiology at Fulton County Medical Center in McConnelsburg, Pa. In addition, Dr. Pyatt was named medical director of the Cumberland Valley Health Network in December 1995.

An ACCME national surveyor and a member of the Board of Examiners of the Malcolm Baldrige National Quality Award, Dr. Pyatt is a noted CME consultant and surveyor throughout the U.S. He is the past chairman of the Pennsylvania Medical Society Commission on CME and is the editor of the Pennsylvania Medical Society CME Newsletter.

A fellow of the American College of Radiology, Dr. Pyatt is pursuing his master of medical management degree with ACPE, as well as the certificate

Pyatt

program and ABMM Boards. In addition, Dr. Pyatt is working on his Board Certification with the American Board of Quality Assurance and Utilization Review Physicians.

For his address at the workshop, Dr. Pyatt will discuss data and patient driven needs, profiling and performance measurements, connectivity and many new concepts. He is encouraging anyone who is planning on attending the meeting to phone in any "hot issues" they want discussed. If you have a topic or question you want addressed, contact Nancie Albright, WVSMA associate executive director, at 1-800-257-4747.

After Dr. Pyatt's lecture and a brief break, the following concurrent sessions are scheduled from 11:15 a.m. - noon: *"Site Surveyor Workshop (Part* 1) with

CME
into the Next Millenia: Wild and Wonderful

Dr. Traubert and Dr. Terry Elliott of Wheeling; *"Alternative Formats for Program Design,"* with Robin Rector, M.A., of CAMC; and *"Step-by-Step Planning of a 1/2 Day - 2 Day CME Program,"* with Thelma Wilson, M.A., of the Raleigh County Medical Society.

Box lunches will be provided at noon and then at 1 p.m. the concurrent workshops will reconvene with: *"Site Surveyor Workshop (Part II)* by Dr. Traubert and Dr. Elliott; *"Do's and Don'ts of Commercial Support,"* by Nancy Joiner of The Upjohn Company, and Clara Clay of the West Virginia Academy of Otolaryngology; and *"Step-by-Step Planning of an Annual Meeting,"* by Clara Clay.

Following a break, a panel discussion will take place at 2 p.m. moderated by Dr. Traubert. The topics for this session will be *"Ethics in the Practice of CME"* and *"Planning for the Future - Let's Talk Collaboration."* The meeting will then conclude at 3 p.m. after evaluations are completed.

To register for the workshop, phone Tim Allman at (304) 925-0342 or fax in the form which appears on page 161.

Board of Medicine License Renewal Deadline: Friday, June 28, 1996 at 4:30 p.m.

This is the year for renewal of licenses to practice medicine and surgery for those physicians whose last names begin with any of the letters from A - L. Renewal forms will be mailed out by the Board of Medicine in May to all those physicians whose last names begin with the letters A - L. It is the responsibility of each licensee to inform the Board of his/her correct address and of any change of address.

A completed renewal form with all the required information provided must be **received** at the Board office by Friday, June 28, 1996, at 4:30 p.m., in order to avoid **suspension** of a medical license effective July 1, 1996. Suspension of a medical license may have several negative consequences, including that a physician may not lawfully care for patients or bill for patient care until the license is reinstated. There may be difficulties with malpractice insurance during the period of suspension.

Please pay attention to any and all mailings from the Board of Medicine. If your last name begins with any of the letters A - L, and for some reason you have not received your renewal form by mid June, please contact the Board office at (304) 558-2921.

Medical Assurance wins all cases taken to court in West Virginia

According to Medical Assurance Vice President Chuck Ellzey, Medical Assurance has won every lawsuit they've tried and taken to court since they entered the courtroom scene in West Virginia in January 1994.

"We're very proud that no Medical Assurance insured physician has suffered a loss to date in the courtroom," Ellzey said. "Defense verdicts are important in the courtroom, but equally important is the fact that 10 cases have been dismissed before trial began. These are cases in which the defense has won dismissal of the defendant physician due to a lack of plaintiff's evidence, a lack of expert testimony for the plaintiff, etc. These court-ordered dismissals are important because they indicate that Medical Assurance's aggressive defense philosophy is working," he added.

In cases without merit, the plaintiff attorneys are told from the start that the case will be disposed of in only one of two ways - - either by jury verdict or dismissal. Many insurance companies simply seek to settle cases, whether meritorious or not - - an action which can stain a physician's reputation and result in a report to the National Practitioner Data Bank. On the other hand, Medical Assurance will defend non-meritorious cases because they believe that settling simply breeds more lawsuits.

If you would like to know more about the Medical Assurance, , please call Chuck Ellzey at 1-800-331-6298 or 346-8228 in Charleston.

Medical Assurance

JAZZ IT UP
at
The Greenbrier During the WVSMA's Annual Meeting

A special evening of jazz with WVU musicians is being planned for Friday, August 23 from 9:30 p.m. - 11 p.m.

Please see the July/August Journal for details!

International medical grads to hold annual meeting in Charleston

The American College of International Physicians' 21st Annual Convention will take place July 18-21 in Charleston at the Marriott Hotel.

This four-day event will begin with a reception hosted by the West Virginia State Chapter on July 18. The meeting will include CME credits from CAMC for AMA's Category I. Clinical topics will be offered on July 19, and on July 20 medical licensure and managed care will be discussed. The meeting will also feature a variety of other activities including youth and Alliance events, a fellowship ceremony, sporting events, and an international ball.

For more information, contact Dr. Rano S. Bofill, 309 W. Avis Ave., Man, WV 25635; (304) 583-2998.

Otolaryngology alumni conference set for June

The Seventh Annual Otolaryngology Alumni Conference, sponsored by the WVU Department of Otolaryngology and the West Virginia Academy of Otolaryngology, will be held June 14-15 at the Robert C. Byrd Health Sciences of Center of WVU in Morgantown.

This year, the Philip M. Sprinkle Lectureship will be given by Michael D. Maves, M.D., M.B.A., executive vice president of the American Academy of Otolaryngology - - Head and Neck Surgery. He will discuss thyroid cancer and give an update on health care reform, including capitation.

The other CME topics to be offered at the meeting include *"Management of Paragangliomas," "Value of PT/PTT in Predicting Post-Tonsillectomy Hemorrhage," "Causes of Failure in Functional Endoscopic Sinus Surgery," "Chemical Face Peel of the 90s,"* and *"Recent Advances in Cochlear Biology."*

To obtain more information, phone Carol Panepinto at (304) 293-4921.

Classified

FOR RENT - Physician's medical office located in downtown Madison, W.Va. Nice waiting area, receptionist billing room, central heat and air conditioners, restroom facilities, six exam rooms. Call Madge Mitchell at (800) 260-3039 or (304) 369-3061.

The 1996 WVSMA Annual Meeting
August 21-24, 1996
The Greenbrier

Scientific Topics Include:

- *"Marfan's Syndrome,"* Gordon F. Murray, MD
- *"Interventional Cardiology: Promises Fulfilled?"* Kenneth M. Kent, MD
- *"Office Evaluation of Children with Suspected Heart Disease,"* William A. Neal, MD
- *"Non-surgical Treatment of Heart Disease,"* Stafford G. Warren, MD
- *"Graduate Surgical Education - At Risk,"* ***T. L. Harris Address*** Gordon F. Murray, MD
- *"Bugs & Drugs - An Antibiotic Selection Overview,"* ***E. B. Flink Address*** Joseph H. Talley, MD

If you haven't registered for the WVSMA's 1996 Annual Meeting to be held at The Greenbrier, you will want to do so immediately. You won't find a better bargain anywhere with a registration fee of only $125 for members and $175 for non-members. For the registration fee, you get CME hours, four receptions, volleyball and sensational jazz entertainment.

Please be sure to make hotel reservations early by calling (800) 624-6070. For more information about other hotels in the area, contact the WVSMA at (304) 925-0342. For your convenience, you may register for the conference by calling the above number and using your Visa or MasterCard.

1996 WVSMA Annual Meeting

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

County _____ Specialty _____

Payment by: ___ Check ___ Visa ___ MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	_____
	non-member	$175	_____
Lunch & Learns	**(Thursday, Aug. 22)**		
	physician	$50	_____
"Physician-Assisted Death"	spouse/student	$35	_____
"Treatment with Controlled Substances -- How to Keep Your License"	**(Friday, Aug. 23)**		
	physician	$50	_____
	spouse/student	$35	_____
	TOTAL		_____

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs for physicians which will be held in the state and region. Unless otherwise noted, these events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization printed in the *Journal*, contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

May 22
"Physician-Assisted Suicide: A Critical Analysis," Robert C. Byrd HSC

May 31 - June 2
"Wilderness Medicine Seminar," Charleston Marriott

June 14
"Pediatric Alumni Reunion Education Day," Robert C. Byrd HSC

June 20
(Teleconference) Exercise-Induced Asthma and Other Related Syndromes," noon-1 pm

August 3-4
"Advanced Trauma Life Support," CAMC Education and Training

Marshall University School of Medicine - Huntington

August 5
"Lung Cancer," L. Einhorn, M.D., of Indiana University, Radisson Hotel, 6:30 p.m. (Huntington Blood Club meeting)

August 6
"Testicular Cancer," L. Einhorn, M.D., of Indiana University, St. Mary's Hospital, Room 2109

Until there's a cure, there's the American Diabetes Association.

Huntington Medical Community Foundation - Huntington

May 21
"Burnout, Crisis, Denial and Other Minor Irritants," John P. MacCullum, M.D., Williamson Memorial Hospital, Williamson, W.Va., 6:30 p.m.

June 6
"Ethics in an Acute Care Setting," Hoyt Burdick, M.D., and Sister Diane Bushee, Putnam General Hospital, Hurricane

June 12
"Differential Diagnosis of the Red Eye," Joseph A. LoCascio, M.D., Williamson, W.Va., 6:30 p.m. (Tug Valley Medical Society Meeting)

June 18
"TBA," Logan General Hospital, Logan, noon

June 27
"Foreign Bodies in the Gastrointestinal Tract of Children," Yoram Elitsur, M.D., St. Joseph's Hospital, Parkersburg, 7:10 a.m.

July 18
"TBA," Pleasant Valley Hospital, noon

Robert C. Byrd Health Sciences Center of WVU - Morgantown

July 25-27
"1996 Summer Intensive Course in Medical Ethics"

Join Us
THERE'S NOTHING MIGHTIER THAN THE SWORD
AMERICAN CANCER SOCIETY®
Call toll-free 1-800-ACS-2345

Outreach Programs

Chapmanville ☐ Logan Country Club, May 22, 6:30 p.m., "Treatment of COPD and Asthma," Juan D'Brot, M.D. and Chandra Kumar, M.D.

Fairmont ★ Fairmont Clinic, July 17, 1 p.m., "Chest Pain in Children and Adolescents," Lee Pyles, M.D.

★ Fairmont General Hospital, 7:30 p.m., "Attention Deficit Disorder," Jennifer Forester, MSW

New Martinsville ★ Wetzel County Hospital, June 13, 7 p.m., "Pain Relief in OB: What's New?" Christine Bezouska, M.D.

★ Wetzel County Hospital, July 11, 7:30 p.m., "Current Therapy of Allergic Disease," Paris T. Mansmann, M.D.

Petersburg ★ Grant Memorial Hospital, May 28, noon, "Evaluation and Treatment of Angina," Anthony Morise, M.D.

Philippi ★ Broaddus Hospital, June 3, 1 p.m., "Signs and Symptoms of Drug/Alcohol Abuse in the Adolescent," Diane Market, ACSW, CAC

★ Broaddus Hospital, July 11, 1 p.m., "Injury Prevention for the Elderly," Janet Williams, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, May 23, noon, "TBA"

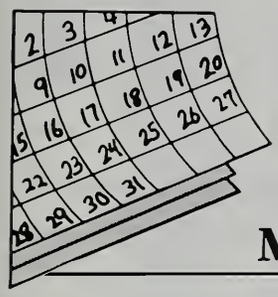
Weston ★ Stonewall Jackson Memorial Hospital, June 10, 8 p.m., "Allergic Rhinitis," Nevin Wilson, M.D.

Williamson, Ky. ☐ Wiliamson Appalachian Regional Hospital, May 23, 5:30 p.m., "White Cells," Karl Klapproth, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, June 24, 4 p.m., "Detecting Breast Cancer," Judith Schreiman, M.D.

★ The Greenbrier Clinic, July 22, 4 p.m. "Current Indications of Carotid Endarterectomy," Kenneth Granke, M.D.

★ *Robert C. Byrd HSC of WVU*
☐ *Charleston Area Medical Center*



Medical Meetings

June

2-4–8th Annual Meeting of the Society for Light Treatment and Biological Rhythms, Bethesda, Md.

5-8–Advanced Echocardiography and Doppler Ultrasound 1996 (sponsored by American College of Cardiology), San Diego

6-8–Advanced Catheter Ablation of Cardiac Arrhythmias (sponsored by American College of Cardiology), Bethesda, Md.

6-9–The Society for Computer Applications in Radiology's Symposium on Computer Assisted Radiology, Denver

16-20–American Orthopaedic Society for Sports Medicine, Orlando

19-20–Origins of Breast and Prostate Cancer (sponsored by GM Cancer Research Foundation), Bethesda, Md.

19-22–American College of Occupational and Environmental Medicine's Impairment and Dis/Ability Evaluation Courses, San Francisco

19-22–Third Annual Intensive Review of Internal Medicine: An Update for Clinicians (sponsored by George Washington University), Arlington, Va.

21-27–American Society of Neuroradiology, Seattle

23-27–AMA's Annual Meeting, Chicago

23-28–MRI Orthopedic Workshop (sponsored by MRI Education Foundation, Inc.), Vienna, Austria

24-28–Two-Dimensional Echocardiography and Cardiac Doppler: The 11th Annual Core Curriculum (sponsored by American College of Cardiology), Lake Buena Vista, Fla.

July

10-15–National Association of EMS Physicians, San Diego

11-12–Society For Biomaterials Bone and Cartilage Repair Course, Denver

18-19–Medical Device Biocompatibility: From Material Screening to Final Product Testing (sponsored by Society For Biomaterials), Baltimore

18-21–American College of International Physicians' 21st Annual Convention, Charleston

27-29–American Academy of Neurological and Orthopaedic Surgeons, Las Vegas

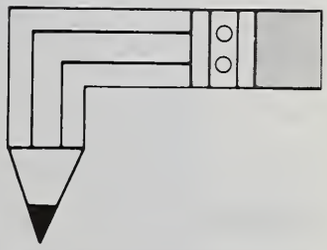
29-August 2–Dynamic Psychotherapy in the New Era: Possibilities and Problems (sponsored by American Psychiatric Association), Aspen

August

21-24–WVSMA's 129th Annual Meeting, White Sulphur Springs

For More Information...
Contact the Journal at (304) 925-0342

Poetry Corner



Four and A Half

I awoke today with
pain in my chest
and went
to my local ER

It's gas they said
or all in your head
you've been working
much too hard

So I went to the druggist
with script in hand
and much
to my dismay

The capsule which had been
prescribed for my gas
came to four and a half
per day

But the pain came back
late one night
and an angiogram
came up next

Your arteries are swell
take this to be well
for you are
truly vexed

So with script in hand
to the druggist my man
who I swear was humming
a tune

The register rang
and I know that he sang
that's four and a half
times two.

P. Van Swearingen, M.D.

Tissue

Tissue has memory,
it leaves a scar;
marking territory
of what's gone so far.

Filamentous and strong,
conjugate of each cell,
it courses a long
way...to end pell-mell.

So tenders the fate,
to dissipate once sown;
but seen in aggregate,
certainty from uncertainty is grown.

Then comes the time when tissue
must yield to the issue.

John Henry McWhorter, M.D.

Department of Health & Human Resources

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Report profiles injuries to state's adolescents

A new report entitled *"The West Virginia Adolescent Injury Profile"* has been published by the Adolescent Health Initiative of the West Virginia Bureau for Public Health's Office of Maternal and Child Health to evaluate the impact of injuries to young people.

The first study of adolescent injuries and deaths in the state, this report reviewed data from 1984 - 1993 to help educate young people about the risks of speeding, driving under the influence of alcohol and drugs, failure to use seatbelts and helmets, and use of firearms.

According to the report, injury is the number one killer of adolescents in West Virginia, taking more lives than all diseases combined. More than half of all injury-related deaths among young people occur from automobile crashes, with the second leading cause of deaths resulting from the use of firearms. Adolescent males are more than twice as likely as females to die in a motor vehicle accident, three-and-a-half times more likely to commit suicide, four times more likely to be killed by firearms, and over five times more likely to drown.

Although many young people die from injuries sustained in accidents, non-fatal injuries far outnumber deaths. Even though the actual number of adolescent injuries cannot be determined because of inaccurate reporting, it is estimated that there are 40 injury-related hospitalizations and 1,300 ER visits for each injury fatality. In West Virginia, injuries represent 6.3 percent of hospital admissions with associated costs of over $150 million annually.

Since most adolescent health problems result from risk-taking behaviors, the report focuses on prevention education for young people through schools, churches, youth groups and community organizations. The Adolescent Health Initiative works with a network of eight regional adolescent health specialists in the state to develop education and prevention activities in communities.

For more information or for a copy of the report, call the Adolescent Health Initiative at 304/558-5388.

Appalachian lifestyles highlighted in study

A comparison of selected health behaviors and characteristics among people living in Appalachia and the rest of the U.S. can be found in a recent study entitled *"Health Risks: The Appalachian Lifestyle,"* which was conducted by the Bureau's Office of Epidemiology and Health Promotion (OEHP), in collaboration with the WVU Prevention Research Center.

The Appalachian area, as defined by the Appalachian Regional Commission, includes 399 counties in the 13 states of Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia and West Virginia. Of these, West Virginia is the only state to lie wholly within Appalachia.

The report looks at cigarette smoking, alcohol use, obesity, weight problems, hypertension, and seatbelt use. Overall, Appalachian residents were found to be at significantly higher risk of injury and illness from not using seatbelts, obesity, overweight, and cigarette smoking, while at significantly lower risk of injury and illness from alcohol abuse than were non-Appalachian residents. Although Appalachian residents were at higher risk for hypertension, this difference was not statistically significant.

Appalachia was found to have a higher percentage of women (53%) than the rest of the U.S. (51%), as well as an older population, with 14% of its residents being 65 years of age or older in 1990, compared to 12% in non-Appalachia. Nearly 92% of Appalachia residents were white, compared to 79% in other areas of the country. On average, Appalachians were found to be poorer and less educated, with the 1989 per capita income in Appalachia being $11,704, while it was $14,667 in non-Appalachia. Of adults aged 25 and older, 32% were high school dropouts, compared to 24% of their peers in non-Appalachia.

For more information on the report, or for a copy, call the Bureau's OEHP at (304) 558-9100.

Final report released on 1994 vital statistics

The Bureau's 1994 West Virginia Vital Statistics confirms provisional data released last summer which shows that West Virginia has reached a record low infant mortality rate.

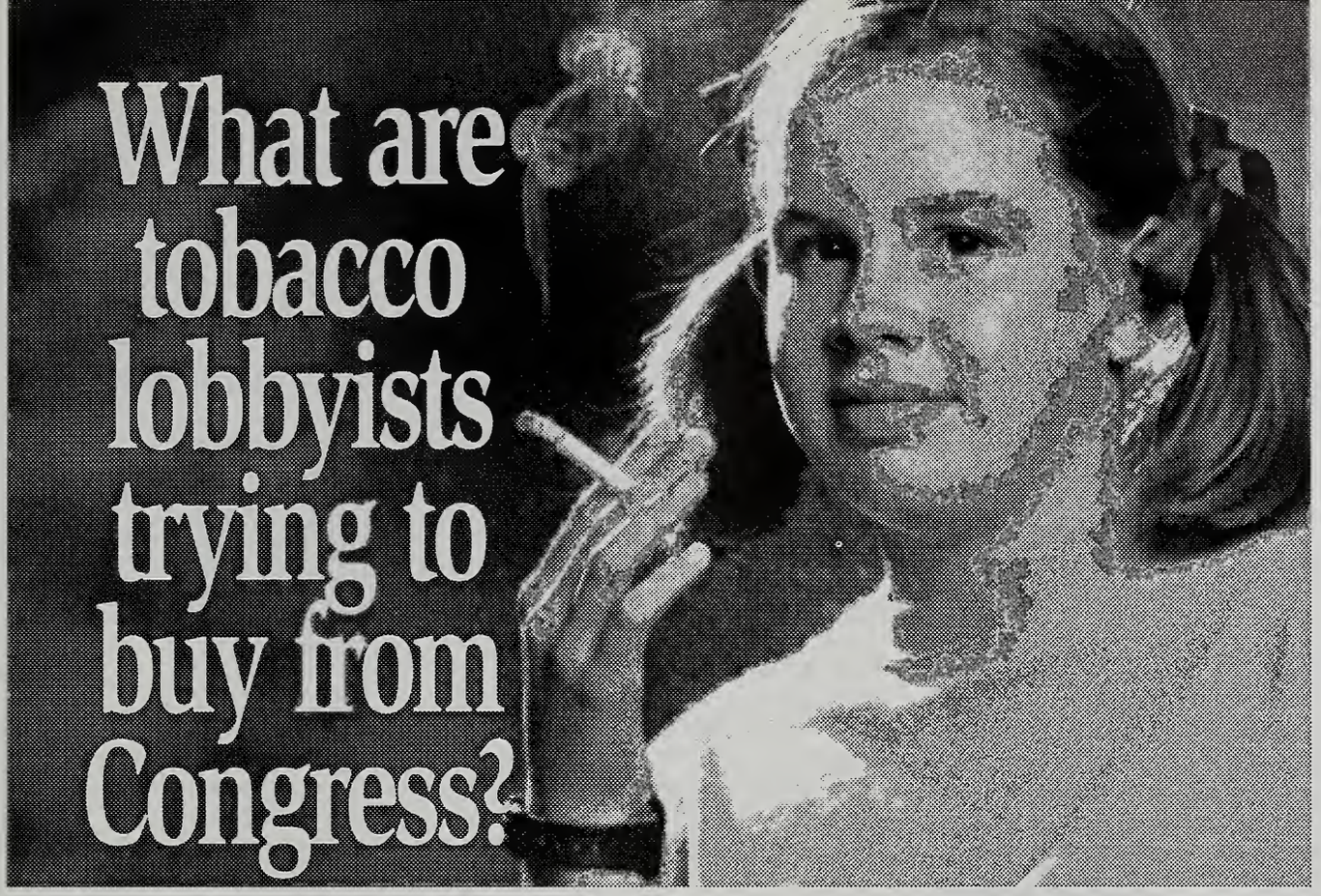
According to the statistics, infant deaths dropped to 131 in 1994 for a rate of 6.1 infant deaths per 1,000 live births. That compares to an 8.6 infant mortality rate in 1993 and marks a true victory for those involved in the improvement of the accessibility, availability and utilization of prenatal care.

The annual report, compiled by the Bureau's Office of Epidemiology and Health Promotion, also shows a 20% decline in motor vehicle accident deaths in 1994, most likely as a result of the state's seatbelt law which went into effect in September 1993. Overall, deaths decreased in 1994 to 19,945 from 20,331 in 1993, and the state's population grew for the fourth year in a row.

The total births in 1994 was 21,360 compared to 21,793 in 1993. Births to teens decreased to 3,721 in 1994 from 3,827 in 1993. Teenage births to unwed mothers continued to increase from 60% in 1993 to 63% in 1994. Some 80% of mothers began prenatal care during their first trimester, but 26% of women continued to smoke during pregnancy and 1.3% drank alcohol. A total of 24% of the state's births were by C-section compared to a 22% national rate in 1992 (latest data available).

The average age at death in West Virginia in 1994 was 69.3-years-old for men and 75.8 or women. Heart disease, cancer and stroke remained the leading causes of death. The number of heart disease and cancer deaths did decrease, but the number of deaths caused by stroke increased. The state's mortality rate for heart disease was 15% higher than the national average, the rate for cancer was 9% higher, and the rate for stroke was 1% higher. Larger differences were noted for deaths due to diabetes (39% higher than the national average), chronic obstructive pulmonary disease (28% higher), septicemia (22% higher), and nephritis (21% higher).

For more details or for a copy of the report, call (304) 558-9100.



After decades of lying about addiction and disease, tobacco companies have launched a last-ditch scheme to continue marketing to kids: flood Congress with cash.

During the first half of 1995, tobacco industry contributions to political parties skyrocketed more than 400 percent. Tobacco companies gave more than $1.6 million ($1.5 million to Republicans), becoming the GOP's largest donor by far.

Why the sudden surge? President Clinton and Members of Congress from both parties are backing new limits on tobacco marketing to kids—limits that could save thousands of children from addiction, disease and death. Tobacco companies are desperately trying to buy opposition.

Voters want Congress to say no to the tobacco industry. More than 85 percent say Congress should support the administration's effort to protect children.

Write your Members of Congress today (U.S. Senate, Washington, DC 20510; U.S. House of Representatives, Washington, DC 20515). Tell them ***America's children aren't for sale.***

To learn more, call ***1-800-284-KIDS.***

CAMPAIGN for TOBACCO-FREE Kids

This ad sponsored by the Congress of National Black Churches; American Academy of Family Physicians; National Association of Elementary School Principals; Catholic Health Association; InterHealth/Protestant Health Alliance; National Association of County and City Health Officials; National Association of Evangelicals; American Public Health Association; General Board of Church and Society of the United Methodist Church; Secondhand Smoke Awareness Program, National Medical Association; and NETWORK: A National Catholic Social Justice Lobby.

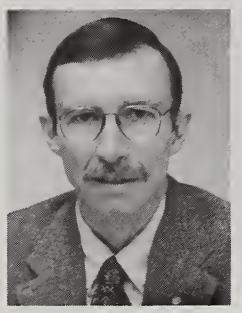
ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Drs. Khakoo, Overman receive Outstanding Teaching Awards

Khakoo



Overman

Rashida Khakoo, M.D., a professor in the Department of Medicine, and Dennnis Overman, Ph.D., an associate professor in the Department of Anatomy, are two of six WVU faculty members chosen by their peers to receive 1995-96 WVU Foundation Outstanding Teaching Awards.

Dr. Khakoo, chief of the section of infectious diseases, is being recognized for her accomplishments in teaching and research. Colleagues noted her work to educate West Virginia's health care providers about AIDS.

Dr. Overman has a joint appointment in the School of Dentistry's Department of Orthodontics and serves on the Executive Committee of the WVU Faculty of Genetics/Development Biology. He has taught histology at WVU at undergraduate, graduate and post-doctoral levels since 1971. Dr. Overman is currently developing interactive computer-based histology courses for undergraduates.

Majority of grads choose primary care

For the third consecutive year, a solid majority of the graduating class of the WVU School of Medicine have been accepted into postgraduate training programs in primary care fields.

Of the 72 graduates in the Class of 1996, 40 (56%) will be in family medicine, internal medicine, pediatrics, or obstetrics/gynecology, and 31 (44%) will start specialty programs. (One student is taking a leave of absence.)

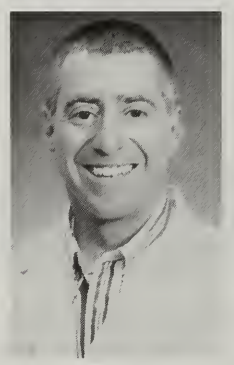
"Students are reacting to the needs of the state and the marketplace in health care," says Dr. Robert D'Alessandri, vice president for health sciences and dean of the School of Medicine. "Eighteen percent of the class chose family medicine. Another 18% chose general internal medicine, and 12% chose either pediatrics or combined medicine/ pediatricsresidencies. Seven percent went into obstetrics and gynecology. These doctors will be West Virginia's primary care providers well into the next century."

Thirty-five students will enter residency programs in West Virginia. The two largest groups of students will train at Ruby Memorial Hospital in Morgantown and at CAMC in Charleston. Dr. D'Alessandri noted that the most popular specialty fields selected, surgery and emergency medicine, were areas of great need in rural West Virginia and in the state's community hospitals.

According to the Association of American Medical Colleges, 14,539 medical school seniors participated in "Match Day," and 77% matched with one of their first three choices.

"At WVU, 79% of the class matched with their first choice, and 93% with one of their first three choices," said Dr. D'Alessandri.

Dr. Fidler elected president of AAP



Fidler

Dr. Donald Fidler of the Department of Behavioral Medicine and Psychiatry has been elected the national president of the Association for Academic Psychiatry.

Dr. Fidler's term will run through March 1997.

Dry eye treatment awarded patent

Charlton

Patients with dry eye will have a new treatment option in the next three to five years, thanks to a WVU physician Dr. Judie Charlton.

Dr. Charlton, an associate professor of ophthalmology, has been awarded a U.S. patent for her dry eye treatment called Urea Ophthalmic Ointment and Solution.

"This formula is different from any dry eye treatment currently available," says Dr. Charlton. "Other dry eye formulas relieve the symptoms by mimicking or enhancing the normal tears. This formula has an active ingredient that actually promotes healing."

In clinical studies, Dr. Charlton's formula, which is derived from a product commonly used in skin preparations, showed evidence of healing corneal surface defects and scarring often associated with dry eye.

Dr. Ivan R. Schwab of the University of California at Davis (formerly of WVU), and Robert Stuchell, D.M.D., of the WVU School of Dentistry, aided Dr. Charlton in developing the treatment.

Rural Health Fair held

Training opportunities in rural West Virginia for students in programs at the Robert C. Byrd Health Sciences Center were the focus of a Rural Health Fair on March 29 at the HSC.

"The fair was held to give our students -- those enrolled in programs in the WVU Schools of Dentistry, Medicine, Nursing and Pharmacy -- information about rural training opportunities that exist for them," says Hilda Heady, associate vice president for rural health.

A University System Board of Trustees mandate requires all health sciences students in the state to complete at least a three-month rural rotation before they can graduate.

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- **Site Surveyor Workshop (Part II)**
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- **Step-by-Step Planning of an Annual Meeting**
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- **Planning for the Future - *Let's Talk Collaboration***

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The WVSMA Committee on Medical Education gratefully acknowledges support for this workshop by The Upjohn Company.

Marshall University School of Medicine

MU
MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Jackman obtains NIH grant to study role of cytokine messages

Susan Jackman, Ph.D., an associate professor in the Department of Microbiology, Immunology and Molecular Genetics, has received a $479,000 federal grant to explore what triggers some immune cells to begin attacking the very bodies they are designed to protect.

With this five-year NIH grant, Jackman will look specifically at cytokines, chemical messengers that help regulate the development, activation and intensity of an immune response. She will look specifically at the sequence of cytokine messages and actions that occur in the earliest stages of an autoimmune response.

"Scientists believe that disturbances in the balance of cytokines contribute to inappropriate immune responses, including autoimmunity," Jackman said. "If we can better understand the role cytokines play, we might be able to control or alter these inappropriate responses."

MU among top med schools for number of primary care grads

A newly released study by the Council of State Governments places Marshall among the leading medical schools in the south in the percentage of grads entering primary care fields.

The report noted that five schools in the 16-state region approached the recommendation by the Council on Graduate Medical Education that 50% of each graduating class be in primary care. In addition to Marshall, which had 40.7% of its graduating class entering primary care fields, the other leading schools were Mercer University (47.4%), and Morehouse College (45.1%) in Georgia; Meharry Medical College (40.9%) in Tennessee; and East Carolina University (39.9%).

The report included data on classes through 1991, and specialty data from AMA mailing lists obtained in April 1995.

Med student to work at Harvard on academic medicine fellowship

Jerome Puryear Jr., a rising 4th-year medical student at Marshall, is one of 34 students nationwide to be selected as 1996 Academic Medicine Fellows.

The fellowship program is sponsored by Bristol-Myers Squibb Company and administered by National Medical Fellowships Inc. Through his fellowship, Puryear will work at Harvard Medical School in July and August with Dr. Robert A. Greenes, director of the Decisions Systems Group at Brigham and Women's Hospital.

Puryear will develop and implement clinical integrated work stations for physician consultation and review. The stations will be designed to give physicians better access to clinical guidelines, reference material (via MEDLINE and the Internet), and other decision support information.

Vascular lab receives special accreditation

Marshall's vascular laboratory has become the first in the Tri-State area to receive accreditation from the Intersocietal Commission for the Accreditation of Vascular Laboratories.

The MU lab provides non-invasive evaluation of upper and lower extremity arterial diseases, anatomic and physiologic studies of extremity venous disease, diagnosis of the extracranial cerebrovascular system, and duplex evaluation of the abdominal aorta and its branches for mesenteric insufficiency and renovascular hypertension.

The accrediting commission is sponsored by 11 medical societies which represent the specialties of radiology, ultrasonography, vascular surgery, neurology, cardiology, neurosurgery and internal medicine.

Walker honored by Governor Caperton

Dr. Robert B. Walker has received the Distinguished West Virginian Award, the highest civilian honor the governor can bestow.

In presenting the award, Gov. Gaston Caperton described Dr. Walker as "a true leader in reshaping the delivery of health care services to rural West Virginians," and noted that he has been nationally recognized as a pioneer in the placement of family doctors in rural communities.

Research Day honors presented to five students, residents

Five students and residents received awards for presentation at the school's ninth annual Research Day, held March 6.

The students and residents who earned honors were as follows:

Khin Thida for *"Nosocomial infection rates in newborns with umbilical or central lines in a neonatal intensive care unit"*;

Dan Lister for *"Valvular heart disease, an under-diagnosed condition in the Huntington, WV, area"*;

Santpal Mavi for *"Muscular dystrophy in a 39-year-old patient"*;

Sejal Desai for *"Effect of retinoic acid on AP-1 expression and function in B16 mouse melanoma cells"*; and

Miniya Berhane for *"Prevalence of lead poisoning in children seen at University Pediatrics"*

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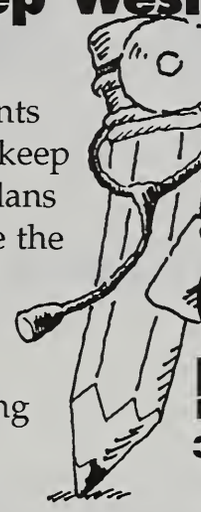

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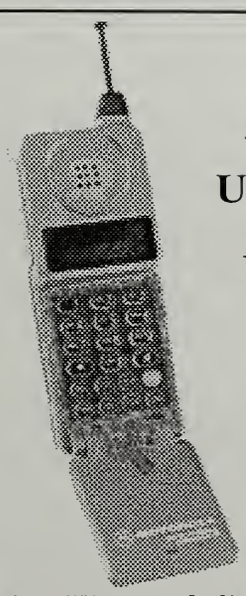

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Alliance News

The Importance of Teamwork

Dear Fellow Alliance Members:

Watching my two daughters play tennis is always interesting, especially when observing how their TEAM supports its members. When one player is winning the others are quiet, attentive, and applaud when a good shot is made. Success feels great, but even if a player is losing, there is still great encouragement offered through frequent applause and cheers of "good shot." It is when players are down that they need the rest of the TEAM the most.

These same principles were in practice at our recent Spring Board Meeting when Alliance members recalled their achievements and failures. No matter if it was a triumph or a disappointment, when members described their experiences they were met with great support and encouragement. "When you talk with a friend, your failures are split in two and your triumphs are doubled." This expression is especially pertinent when you are having problems in your component society, you need the support and encouragement of other members in the state. When you are having successes, you need to hear the applause you have earned.

I believe that everyone attending the Spring Board Meeting learned a tremendous amount through the sharing of each others' activities. Yes, we are a TEAM - - a very supportive one. I want to thank each and every board member who attended for giving priority to the Alliance amidst your busy schedules. Each of you added a great deal to the meeting, at a time when many people are becoming complacent and saying "What good are meetings anyway?" or "I have so much to do that I don't have time for meetings." It is important to remember that every time you share a conversation with someone you are having a meeting. Can you imagine your relationship with your spouse or your children if you didn't have meetings? Your Alliance can only be as good as the time you are willing to spend in meetings making positive interaction.

With this in mind, I urge each of you to attend the WVSMAA's Annual Meeting at The Greenbrier from August 23-24. Our theme this year is *"Christmas in August,"* and we will have two events during the meeting to raise funds for AMA-ERF - - a Greenbrier Cooking Demonstration and a Silent Art Auction. In addition to these two special activities, the recipients of the Doctors' Day and Medical Heritage awards will be announced, as well as the winners of the awards for Alliance Member of the Year and the Best County Alliance. Other meeting highlights will include a variety of business and social events, and the golf and tennis tournaments.

Yes, there is something for everyone at our Annual Meeting, but most importantly it is the perfect time to get to know the many wonderful Alliance members. So, come and join our TEAM!

Linda Elliott
WVSMAA President

New Members

The WVSMA would like to welcome the following new members:

Physicians

Edward J. Doyle Jr. MD
Morgantown

Amarinder S. Chhabra, MD
Oceana

John Langford, MD
Morgantown

Charles A. Moore, MD
Morgantown

Michael Seligson, MD
Morgantown

Dorothea Jackson-Burns, MD
Morgantown

Kenneth Kreisler, MD
Morgantown

Ahmed Aboraya, MD
Morgantown

Safwat Attia, MD
Morgantown

Steven Whitefield, MD
Morgantown

Andrew Berens, MD
Morgantown

Rosemarie Cannarella, MD
Morgantown

Anita G. Fiala, MD
Morgantown

Edwin J. Morris, MD
Morgantown

Joseph B. Selby, MD
Morgantown

Douglas Drevets, MD
Morgantown

H. Carl Palmer, MD
Morgantown

M. Reena Varghese, MD
Morgantown

Edward J. Weinman, MD
Morgantown

John C. France, MD
Morgantown

David F. Hubbard, MD
Morgantown

Michael L. Ferrebee, MD
Morgantown

Marybeth Hogan, MD
Morgantown

Hatim M. Omar, MD
Morgantown

Kumaravel Rajakumar, MD
Morgantown

Demir Bastug, MD
Morgantown

Thuan-Phuong Nguyen, MD
Morgantown

Elias Arbid Jr., MD
Morgantown

Dale B. Lilly, M.D.
Huntington

Mitchell Toomey, MD
Huntington

John Iaquinto, MD
Huntington

Leonard A Fichter, DO
Hurricane

Alaa Ujayli, MD
Beckley

Cynthia S. Reese, MD
Ripley

Galal Z. Galal, MD
Beckley

Jerome C. Arnett, MD
Elkins

Residents

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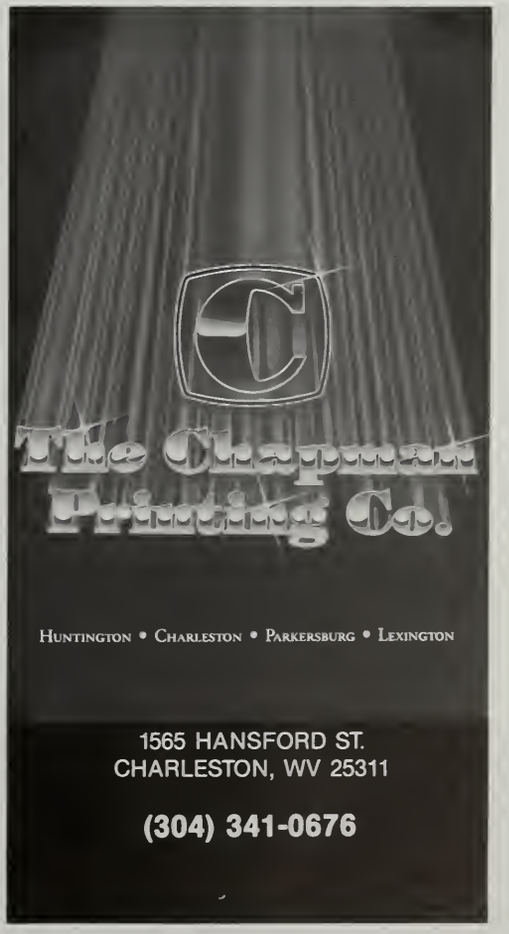

A new year of possibilities

Dear Fellow Medical Students:

Hello and welcome to a new year. Let me begin by extending my sincere thanks to all of you for allowing me this opportunity to represent you as the president of the Executive Council of the WVSMA-MSS. Thanks to the hard work of the Executive Council members and officers of the past, we have a solid foundation on which to build. I look forward to working with all of you to increase membership, expand existing programs, and create new programs to offer opportunities for others to become involved. Through these efforts, I hope the MSS will grow even stronger and allow us to continue the outstanding reputation established by previous councils.

At this time, I would like to announce the other WVSMA-MSS Executive Council members for 1996-97 - - Kristin DeHaven, vice president; and Stacy Jones, secretary/treasurer. I encourage you to contact me or any of these other officers at anytime to express your ideas and concerns.

At our Executive Council Meeting on May 18, we discussed our agenda for the upcoming year, made plans for attending the AMA' Annual Meeting in Chicago in June, and heard reports from the members who participated in the AMA's Leadership Conference in Washington, D.C., and the WIMOK Meeting in Toledo, Ohio. I want to extend a warm invitation to all members to attend any Executive Council and Component Society meetings, as well as other MSS functions because your ideas are always welcomed and appreciated.

In closing, I would like to leave you with this thought: The best career decisions, like other decisions, are made after gathering all the necessary knowledge to make an educated informed decision. The WVSMA-MSS is one of the most effective ways of keeping medical students informed about current health care issues that may affect our personal and professional lives both now and in the future.

Again, thank you for this experience and I look forward to working with all of you this year.

Sincerely,

Melissa Matulis, MSIII
WVSMA-MSS President

Obituaries

Lawrence B. Gang, M.D.

Dr. Lawrence B. Gang, 87, of Huntington, died March 15 at his residence.

Dr. Gang was born in New York City and received his medical degree from New York University College of Medicine in 1931. He interned at Beth Israel Hospital and Fordham Hospital in New York, where he also did postgraduate studies.

In 1937, Dr. Gang began practicing internal medicine in Huntington. He served in the U. S. Navy Medical Corp. during WWII and achieved the rank of lieutenant commander.

A Fellow of the American College of Physicians and a Diplomate of the American Board of Internal Medicine, Dr. Gang was a past president of the Cabell County Medical Society and a member of the WVSMA since 1938. Dr. Gang was the first president of the medical staff at Cabell Huntington Hospital and served as a board member for 12 years. He also was a past president of the medical staff at St. Mary's Hospital.

Devoted to the Huntington community, Dr. Gang served as a member of the Planning Commission for the City of Huntington and he established an endowment at the Huntington Museum of Art for a lecture each year. In addition, Dr. Gang was active in the Huntington Chamber Orchestra for 25 years and served on its board. He was a member of the B'Nai Sholom Congregation.

Dr. Gang was preceded in death by his first wife, Shirley Ginsberg Gang, who was a past president of the Cabell County Medical Alliance. His survivors include his wife, Jean Higgins Gang; three sons and their wives, Dr. David L. and Roberta H. Gang of Longmeadow, Mass., Robert C. and Adrienne J. Gang of Miami, Fla., and Lawrence C. and Eileen S. Gang of Baltimore; grandchildren, Nicholas and Jonathan Gang of Longmeadow, Mass., Taylor and Barclay Gang of Miami, Fla., Adam Gang of Newton, Mass., and Alexander and Christopher Gang of Baltimore; two brothers, Arthur J. Gang of Chevy Chase, Md., and Robert A. Gang of Bethesda, Md.; and a brother-in-law, David Ginsberg of Alexandria, Va.

Memorials may be directed to the Shirley and Larry Gang Memorial Fund at the Huntington Museum of Art.

Judy C. Kandzari, Ph.D.

Dr. Judy C. Kandzari, 52, wife of Dr. Stanley J. Kandzari Jr. of Morgantown, died March 1 at Ruby Memorial Hospital after a car accident.

Dr. Kandzari was born in Gary and earned four degrees at WVU. After completing her bachelor's degree in nursing in 1965, she worked one year as a pediatric nurse in the hospital at the University of North Carolina at Chapel Hill, and then returned to WVU where she taught for 29 years.

During her years on the faculty at WVU, Dr. Kandzari earned a master's degree in counseling and rehabilitation, a master's degree in nursing, and a doctorate in community health education. She had worked her way up the ranks from a teacher's assistant to an associate professor and was also the director of distance education in the WVU School of Nursing. She was a pioneer in the implementation of the Kellogg and Rural Health Initiative programs, and was considered by her colleagues to be an expert in public and community health concerns.

Dr. Kandzari was a member of the Drummond Chapel United Methodist Church and the Eastern Star Morgantown Chapter 35. She was a member of the Alpha Rho Chapter of Sigma Theta Tau International, the Nursing Council for Research in Nursing Education, the American Public Health Association, the American Nurses Association and the American Diabetes Association.

In addition to her husband, Dr. Kandzari is survived by a daughter, Pamela Lynn Kandzari of Charleston; a son, Dr. David Kandzari of Baltimore; and her mother-in-law, Eleanor Kandzari of Granville.

Donations may be made to the American Diabetes Association, West Virginia Affiliate, Inc., 1221A Ohio Avenue, Dunbar, W.Va., 25064.

Athey Ragan Lutz, M.D.

Dr. Athey R. Lutz, 95, who was a Parkersburg physician for more than 50 years and a past president of the WVSMA, died February 19 at his residence.

Dr. Lutz was born in Orkney Springs, Va., and received his medical degree from the Medical College of Virginia in 1927. He interned and studied orthopedics at Charleston General Hospital and the Willis C. Campbell Clinic. A U.S. Army veteran of WWII, Dr. Lutz spent 31 months in the European Theatre and achieved the rank of lieutenant colonel.

In 1937, Dr. Lutz moved to Parkersburg to practice orthopedics, where he cared for patients for 50 years before his retirement in 1975. Dr. Lutz was on the board of both the Wood County Crippled Children's Society and the West Virginia Crippled Children's Society, and received the Distinguished Service Award from the Crippled Children's Division of the Department of Public Welfare. A founding member of the Tri-State Orthopedic Society and one of the founders of Parkersburg Blue Cross/Blue Shield, Dr. Lutz helped bring Hospice to the Parkersburg area.

Dr. Lutz served as president of the WVSMA in 1956 and was a member of the Parkersburg Academy of Medicine. In addition, Dr. Lutz was a member of the American Academy of Orthopedic Surgery, the AMA, the American College of Surgeons, the Willis Campbell Club, the International College of Surgeons and the Latin American Society of Orthopedics and Traumatology.

A past president of the Parkersburg Rotary Club, Dr. Lutz was a layreader at Shrine Mont of Orkney Springs, a lifelong member of the Episcopal Church, and a member of Trinity Episcopal Church in Parkersburg.

Surviving are his wife, Veronica Sammel Lutz; one son, John Sammel Lutz of Davis; two daughters, Katherine Lutz Coppock of Stowe, Vt., and Elizabeth Sammel Lutz of Parkersburg; three grandsons; one brother, Preston Wilber Lutz of New Market, Va.; and two sisters, Hilda M. Grove of Edinburg, Va. and Marjorie Bird of Strasburg, Va. He was preceded in death by one brother, Otho Lutz. Memorials can be made to the Wood County Society of Crippled Children & Adults, P.O. Box 4366, Parkersburg, W.Va., 26104.

WESPAC Members

We would like to thank the following physicians and Alliance members for their 1996 contributions to WESPAC: *(This list includes contributors since the January/February Journal.)*

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Sarjit Singh

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J. Patrick Galey
Teodoro Medina
Carl Liebig
Gerardo Lopez
*Simon McClure
David Waxman

Kanawha
Ronald Cordell
W. Alva Deardorff
Edmundo Figueroa
Sherman Hatfield

Marion
Mani Khatib-Shahidi

Monongalia
James Helsley
Paul Jakubec
Gregory Timberlake
Richard Vaglienti

Ohio
Barton Hershfield
*Steven Miller

Parkersburg Academy
Harry Amsbary
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The **West Virginia Medical Journal** is published bimonthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue SE, Charleston, WV 25304, under the direction of the Publication Committee. Original articles are accepted on the condition that they are contributed solely to the *West Virginia Medical Journal.*

The views expressed in the *West Virginia Medical Journal* are those of the individual authors and do not necessarily reflect the policies or opinions of the *West Virginia Medical Journal*'s editor, associate editors or its staff, or the West Virginia State Medical Association's staff. Publication of an advertisement is not to be deemed an endorsement of any product or service unless otherwise stated.

Subscription Rates:
$45 a year in the United States
$80 a year in foreign countries
$4 per single copy

POSTMASTER: Send address changes to the *West Virginia Medical Journal,* P.O. Box 4106, Charleston, WV 25364.

Entered as second-class matter, January 1, 1926, at the post office at Charleston, WV, under the act of March 3, 1879.

USPS 676 740
ISSN 0043 - 3284

Claims for back issues must be made within the six-month period after publication. Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

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The Cass Scenic Railroad in Pocahontas County.

Photo by Steven J. Shaluta Jr.
West Virginia Department of Commerce.

President's Page

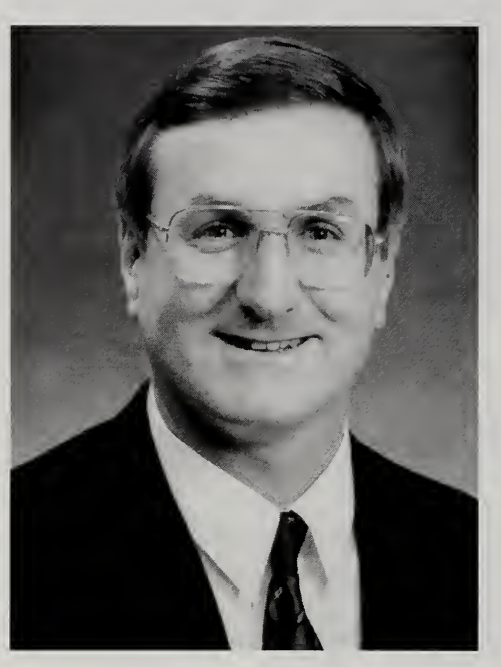
An experience I wish every member could have

Serving as your president this past year has afforded me the opportunity to travel and meet hundreds of West Virginia physicians, as well as numerous other physicians from throughout the United States. For the most part I listened - - listened to what physicians had to say about our profession and their predictions for our future.

As a result of my travels and listening, I have gained a wealth of new insights and I would like to share these thoughts with you:

*Managed care is by far the most discussed topic among physicians. The term "managed care" is itself a terrible misnomer!!! Why??? Because managed care is actually about redistributing health care dollars away from patients and those who earn those dollars, into the pockets of insurance conglomerates, all the while giving the patients less choice and avoiding completely the problem of the uninsured.

*Among the various states in the nation I visited, I found that the levels of experience with managed care varied greatly. It was interesting to hear physicians from one state discussing their pitfalls and mistakes in dealing with managed care, and then turn around and listen to physicians in another state with a less-developed managed care system who were unaware of the fact that they were headed for the same problems. My analysis is that there will be



millionaires made in the managed care business, but there will be very few. The rest of us will continue to struggle to do what we were trained to do - - take care of our patients. In addition, we'll provide even more care, take a greater risk of malpractice, suffer more criticism and receive less in return. We'll continue to accept the status quo until the point where we feel enought pain to alter our behavior.

*Instead of simply adjusting and adapting to change (we are already good at this), as a profession we will have to create the change ourselves. To do so will result in our hands getting a little dirty. Greater involvement in the business aspects of medicine and, more importantly greater involvement in politics are avenues of escape from the forces that control us now. Some of our colleagues have realized this and taken action; the result is a growing number of doctors in political office.

*Physicians have remained calm and slow to anger; however, society is turning up the heat on our profession. We always have and always will be personally liable for our actions. Now, society is redefining the practice of medicine to dictate that we also shoulder the financial liability for the health behavior of our patients. Our only other recourse is political change through political involvement. Rather than turn away and avoid the political arena, physicians will likely take up the challenge with increasing vigor. Actually, I am really looking forward to it.

Next month, I will step aside as president of the WVSMA and Dr. Ronald Cordell will become your leader. I have full confidence that Gene will guide the WVSMA quite well, and I look forward to working with him as Council chairman.

Rather than go on and make this a long-winded goodbye, I just want to extend my most sincere thanks to each and every one of you for allowing me the privilege and honor of serving as president of the WVSMA. It has been an experience I wish every member could have.

James D. Helsley, M.D.

John M. Hartman, M.D., R.I.P.

It is rare to find someone who embodies the old fashioned with the modern. And it might be more rare to find a physician with those qualities - - a doctor known for his gentle understanding way with patients in association with the ability to apply the latest in research and scientific medicine to those patients.

We lost such a man when Jack Hartman died June 26, 1996. He had known he had cancer for a year or more but continued his devotion to his patients until very recently when it became difficult for him to get about.

A relative described him as . . . "a wonderful hand-holder during any illness. You came away from his office feeling like a million dollars and standing tall.

"He worked until he couldn't walk. The courage he showed during his illness was incredible. He gave everyone around him strength while his was leaving."

Jack's association with the *West Virginia Medical Journal* began in 1972 when he was named an

associate editor. Throughout his years in this post, he remained an ever ready source of good humor, good advice and solid comment. His editorials consistently demonstrated his gentle ways and good humor.

Jack was born on January 2, 1928 in Charleston. He received an A.B. degree from WVU in 1949 and his M.D. from the University of Maryland in 1953. He served in the U.S. Navy from 1953-56, during which time he completed his internship at the U.S. Naval Hospital in San Diego.

Following his military service, Jack did his residency at Ohio State University where he was awarded a fellowship in cardiovascular research in 1959. He was an associate professor of medicine at the Robert C. Byrd Health Sciences Center, Charleston Division, and was an active staff member of Charleston Area Medical Center's Department of Medicine.

A past president of the West Virginia Society of Internal Medicine, Dr. Hartman belonged to many professional organizations in addition to the WVSMA. Church and civic organizations also received a generous portion of his time.

The editors and staff of the *Journal* along with the staff of the WVSMA share the grief of his wife, Dolly, their four children, the extended Hartman family, Jack's many patients and his innumerable friends.

Sometime killers

We highly recommend that our readers turn to page 182 and absorb the contents of the Special Report entitled *"The impending legalization of physician-assisted suicide: How should physicians respond?"* which was written by Alvin H. Moss, M.D., director of the Center for Health Ethics and Law at the Robert C. Byrd Health Sciences Center of WVU.

Dr. Moss serves on the WVSMA's Medical Education Committee and his article is moderate in tone, well thought out and sure to be helpful to physicians beset with difficult moral and ethical decisions. It contains valid criticism of many physicians' treatment of pain in seriously and oftentimes terminally-ill patients, which in Dr. Moss' view, has led directly to the dilemma of physician-assisted suicide (PAS).

PAS is in various stages of litigation in several states including a U.S. Supreme Court challenge of the constitutionality of prohibiting PAS in the state of Washington. A prior appeals court ruling in that state held that the ban on PAS protected the poor, the handicapped and the elderly, and prevented doctors from becoming "killers of their patients." This wording is significant and reflects a more widely held suspicion that doctors might be inclined or could be tempted to become such killers.

What has become of the old time, traditional picture of the kindly, gentle and helpful healer of the suffering and afflicted once enjoyed by doctors?

Science and technology have certainly interjected themselves into that picture which reflected the previously held warm and comfortable relationship between doctors and their patients. Attention diverted from the caring and personal interest in patient concerns to the fascinatingly important but cold and impersonal scientific data of modern medicine certainly accounts for the beginning and the major source of the loss of this hallowed relationship. Although the loss is regrettable, it is difficult to fault the diversion of interest in view of the therapeutic gains resulting from attention to scientific detail.

The picture of the kindly old doctor holding the hand of a dying patient showed doctors at what they then did best. Science and technology turned the picture into a sterile one of a white frocked, preoccupied specialist studying a chart in his hand while an anxious patient lies awaiting the calamitous news contained in that chart.

With managed care, the currrent impotence of doctors in effecting control over the fate of their patients has further lowered the esteem and regard of doctors in the succor-seeking eyes of those patients. Little wonder then that the trust and regard previously afforded doctors plummets to the depths indicated by their mistrust as potential killers.

No one seems inclined to ask, "Why *physician*-assisted suicide? Why should *doctors* be designated killers? Why not judges or lawyers, carpenters or plumbers, or just the ancient masked axeman or hangman?

We are astounded at reports that there are groups of doctors advocating and lobbying for the right to be such killers. It's as though it were a noble and heroic thing to do. Something for which they might receive praise and acclaim. Is their pathetic self regard so ground down and decimated that some new found importance as kindly killers is sought?

It just won't work. The arithmetic is simple. There are many, many more people who want to be alive rather than to be dead. We can't afford to risk alienating all of these. And that is exactly what the trendy and ambitious thanatologoists amongst us propose to do. We can all be tarred by the same brush which only they deserve.

Drs. Thomas Reardon and Lonnie Bristow of the AMA have it right. Dr. Reardon, chair of the AMA Task Force on Quality Care at the End of Life says, ". . . Even if patients choose suicide over natural death, this must not be interpreted as a 'right' to have physicians assist them." Dr. Bristow, immediate past president of the AMA, told a committee of Congress that it is unethical for physicians to cross the line and become active agents in a patient's suicide.

Doctors are *HEALERS*. They cannot afford to be, even parttime, killers. If there is to be legalized killing of those intent on suicide, let it be done by other than doctors.

Ours is a noble and healing profession. It is time to start refurbishing the *HEALING* image of our profession.

Stephen D. Ward, M.D.
Editor

America needs health insurance reform. But unfair fraud and abuse laws need a second opinion.

Congress is moving now to pass long-needed legislation making health insurance portable and ending coverage exclusions due to preexisting medical conditions.

Congress is also considering ways to end the discrimination in health care by providing a greater range of treatment choices for patients through Medical Savings Accounts and enhanced coverage of mental illness.

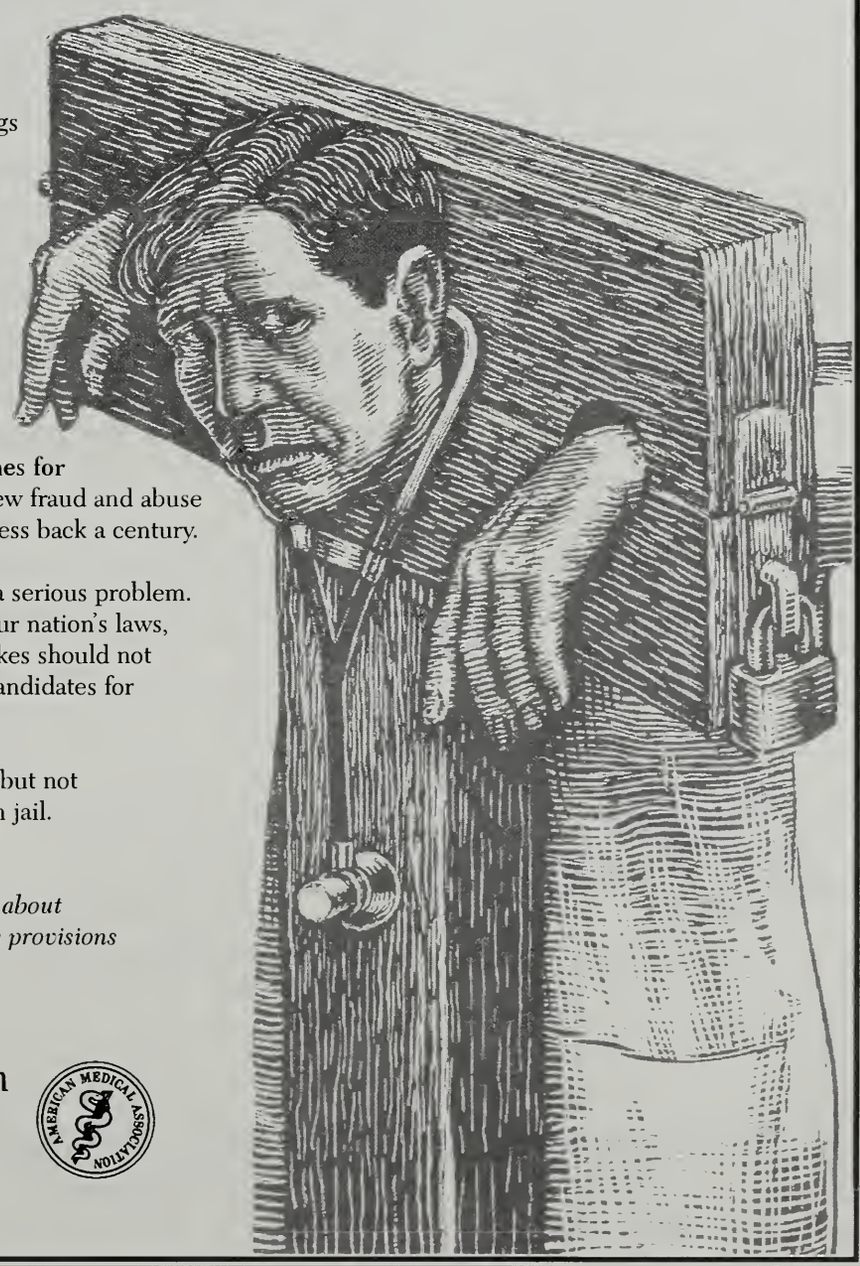
The nation—and our patients— need these reforms.

HOWEVER...some proposals in the House and Senate go too far. Despite months of negotiations, **legislation is now being considered that could put your doctor in jail or exact grossly excessive fines for unintended paperwork mistakes.** These new fraud and abuse laws would set basic principles of due process back a century.

Medicine agrees that fraud and abuse is a serious problem. If doctors willfully and knowingly violate our nation's laws, they should be punished. But honest mistakes should not make physicians—or any other citizens—candidates for incarceration.

America needs health insurance reform...but not unfair laws that will put innocent doctors in jail.

Call the AMA's Grassroots Hotline at 1-800-833-6354 to obtain more information about joining the campaign to strike these onerous provisions from the law.



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Special Report

The impending legalization of physician-assisted suicide: How should physicians respond?

ALVIN H. MOSS, M.D.
Director, Center for Health Ethics and Law; Professor of Medicine, Section of Nephrology, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Introduction

Our failure as physicians to address patients' concerns about pain, suffering, and control over end-of-life treatment has been a major reason that the drive toward legalization of physician-assisted suicide (PAS) is gaining momentum.

PAS legislation was first voted into law in Oregon in November 1994, and its implementation was held up in court. Previously, such referenda had narrowly failed passage in California and Washington.

This year on March 6, judges from the Ninth Circuit Court of Appeals ruled that a provision of a Washington state statute that prohibited PAS violated the due process clause of the 14th Amendment of the Constitution. Then, on April 2, judges from the Second Circuit Court of Appeals ruled that two New York statutes which prohibited PAS were unconstitutional based on the equal protection clause of the 14th Amendment.

Physicians' opinions on PAS

In a 1992 *JAMA* article, Robert Blendon, a Harvard School of Public Health researcher, said that "A majority, or 64%, of Americans believe that, when a terminally ill patient is conscious and in pain, physicians should be allowed by law to respond to a patient's request for lethal drugs or injections to aid in dying."

Two years later in the *New England Journal of Medicine,* an article stated that a majority of physicians in Washington state favor legalization of PAS in some situations. This year in the February 1 issue of the *New England Journal of Medicine*, two articles were published which indicated that a significant minority of physicians in Michigan and Oregon said they would be willing to assist a patient in suicide, and that a majority of physicians in these states now support legalizing PAS.

Further evidence of the growing support for PAS is the failure of three juries to find Dr. Jack Kevorkian guilty of PAS.

Patients' perspective on PAS

Why is it that patients want PAS?

In a 1990 article in the *New England Journal of Medicine,* Cassel and Meier stated that patients are losing faith in their doctors. They reported that patients are concerned that their dying will be prolonged by medical technology over which their physicians will allow them little control, and as a result, they will have to endure considerable suffering. These authors also added that patients view doctors as insisting on life at any cost.

In a study published in the *American Journal of Psychiatry* in 1995, 200 elderly patients dying of cancer were interviewed to find out if they had a desire to die. Seventeen (8.5%) of these patients expressed the desire to die, and these individuals were more likely to report moderate to severe pain, low family support, and symptomatic depression.

The November 22-29, 1995 issue of *JAMA* contained an article on the SUPPORT Study which received widespread media attention and confirmed patients' worse fears. This report revealed that of 9,105 seriously-ill hospitalized patients, 50% died with moderate to severe pain. It also indicated that the physicians of a majority of these patients were not aware of their preferences to avoid CPR, and that 38% of these patients spent at least 10 days in the ICU prior to their death. These outcomes were not improved in a second phase of the study when a nurse specialist placed information in the chart about patient preferences and prognosis.

What lessons are there for physicians in regard to responding to patients' requests for PAS?

In considering this question, physicians must recognize the fact that the vast majority of patients who request PAS are suffering from clinical depression which has been exacerbated by other factors such as poor pain management, a sense that their treatment is out of control, and lack of family support.

There are five actions physicians can take to prevent the escalation of patients' problems that might result in a request for PAS. The first is becoming more proficient in pain management and instituting the guidelines published by the Agency for Health Care Policy and Research. These practices include actions such as believing a patient's report of pain; using a scale from 0 (which means "no pain") to 10 (which indicates "pain as bad as you can imagine); assessing pain repeatedly; giving adequate pain medication; and educating patients to take pain medication properly. The AMA has

advised that "Pain control medications should be employed in whatever dose necessary, and by whatever route necessary, to fully relieve the patient's pain."

The second action physicians need to take is to be alert to the development of depression in their chronically or terminally-ill patients. If depression is present, the physician should immediately begin treatment or refer them if necessary.

Demonstrating respect for patient preferences by eliciting advance directives is the third important step. Throughout the process of advance care planning, physicians should be learning about their patients' preferences and reassuring them they will be respected and carried out. This helps patients feel they have a sense of control over their treatment and destiny.

Next, it is critical to realize the importance of emotional support from loved ones. Physicians need to encourage families to be involved in the patient's care.

The final step that must be addressed is the nature and causes of our patients' suffering. Dr. Eric Cassel in his classic article, *"The Nature of Suffering and the Goals of Medicine,"* which appeared in 1982 in the *New England Journal of Medicine,* wrote that helping patients find meaning in their illness and connnecting them with their spiritual beliefs may reduce their suffering, but that the medical profession appears to ignore the spiritual aspect of patients' lives. He stated that medicine's failure to provide better care for patients who are suffering stems from a lack of knowledge and understanding.

In conclusion, I believe it is now time for physicians to recognize that relief of pain and suffering, control over end-of-life treatment, and addressing spiritual beliefs are important to patients. As physicians, we must provide better care in these areas so that our patients do not reach such a state of despair that they request assistance from us

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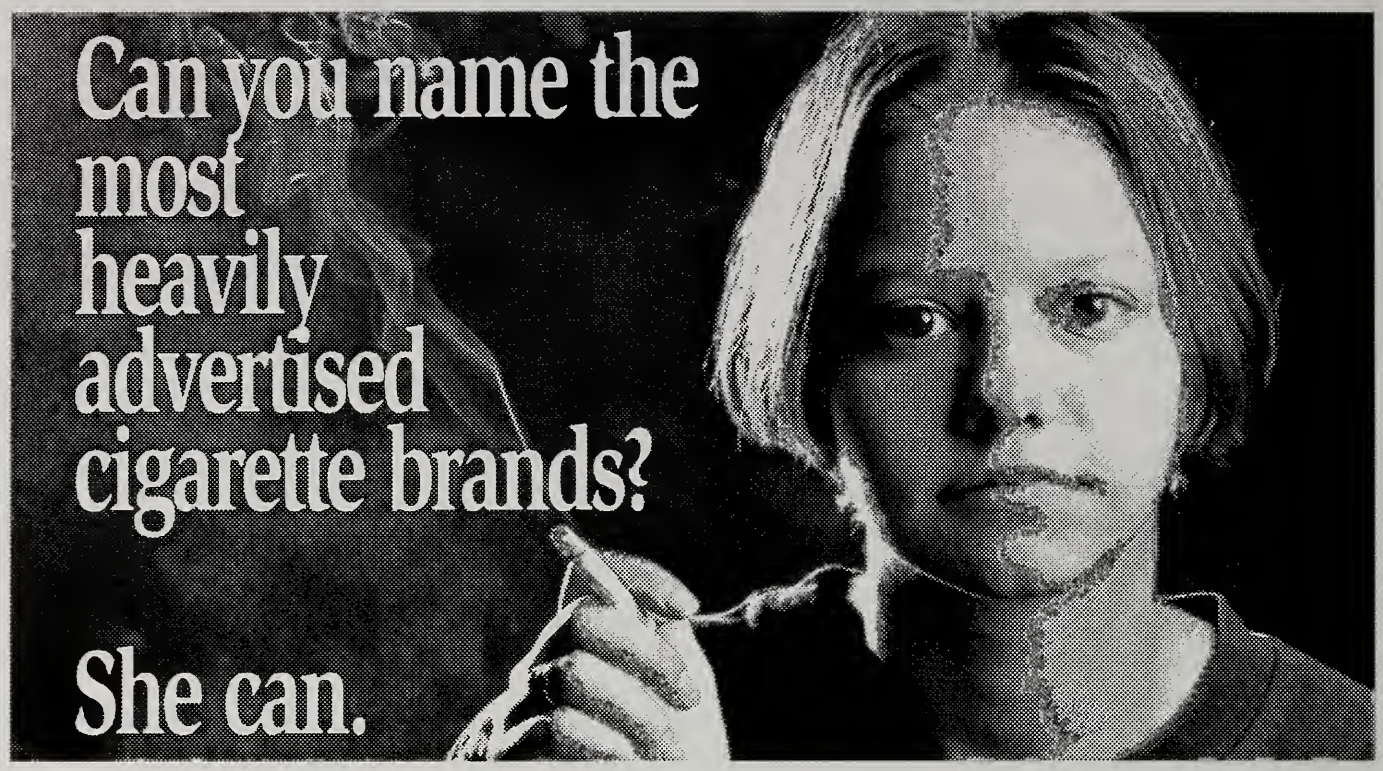

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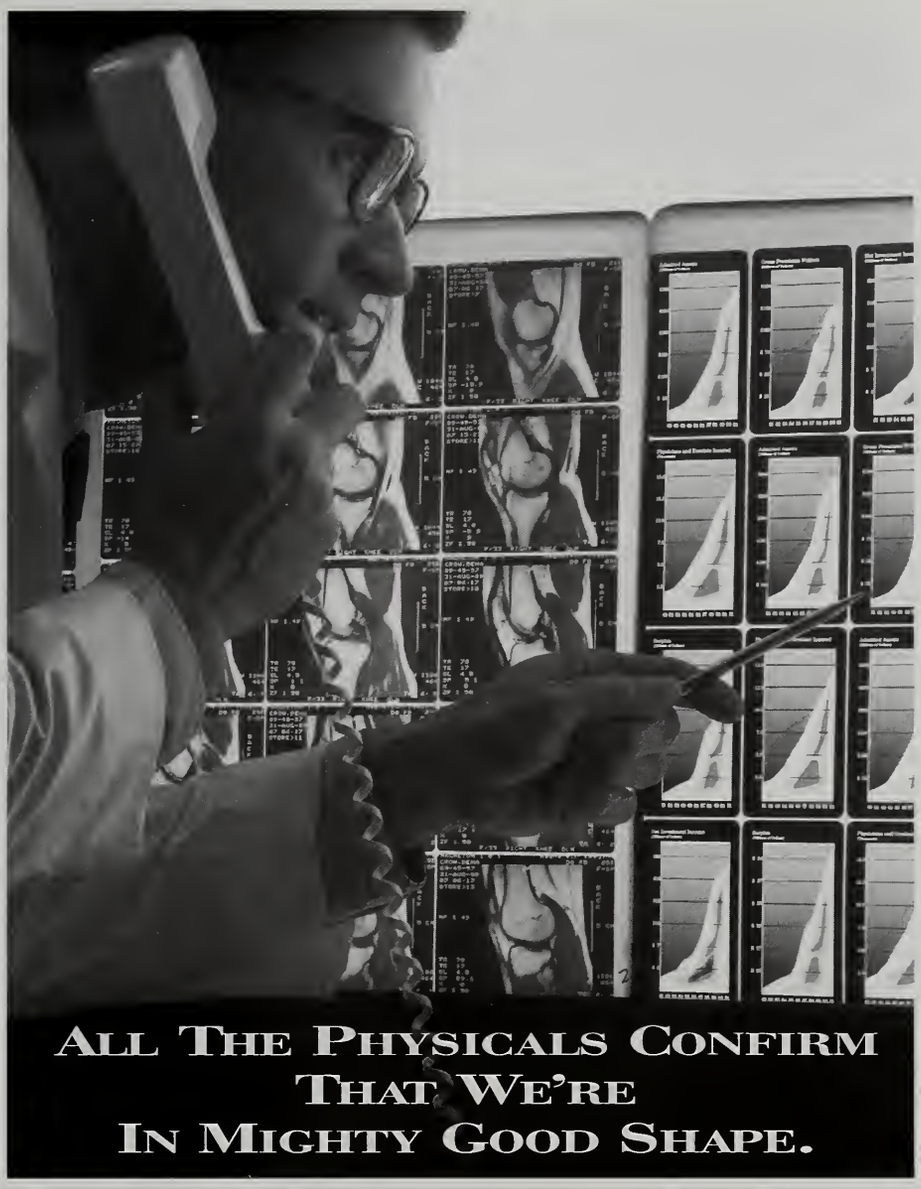

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A review of the treatment and survival rates of 138 patients with glioblastoma multiforme

STEVEN J. JUBELIRER, M.D.
Director, Cancer Care Center of Southern West Virginia, Charleston Area Medical Center, Charleston; Clinical Professor of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division

Abstract

This article reviews the cases of 138 patients at the Charleston Area Medical Center who were treated for glioblastoma multiforme (astrocytoma Grade IV) between 1966-1987. Data was obtained from the hospital's tumor registry, inpatient/outpatient records, pathology reports, as well as radiotherapy records. The median survival rate for all patients was 7 months (range 1 - 36 months). The median survival of the patients who underwent complete resection and received radiotherapy was 12 months, while the median survival rate was four months for patients who had complete resection but did not undergo radiotherapy. In addition, the median survival of the patients who underwent incomplete resection with radiotherapy was 10 months compared to a survival rate of 3 months of those who did not undergo radiotherapy after incomplete resection. Radiotherapy was the most significant predictor of survival with age being the major factor. Despite the clinical advancements made in the past 10-15 years, no impact has yet been achieved on the natural history of glioblastoma multiforme.

Introduction

Kernohan Grade IV astrocytomas (glioblastoma multiforme) are invariably fatal with a median survival rate of only 6 months (1,2). Approximately 90% of patients diagnosed with this tumor die within two years and fewer than 1% of these patients survive 10 years.

This article reviews the treatment patterns and survival rates for 138 patients with glioblastoma multiforme that were diagnosed at Charleston Area Medical Center (CAMC) from 1966 to 1986. This study was undertaken to assess treatment outcomes and to establish a baseline for future trends.

The sources for data included the CAMC Tumor Registry, hospital charts, outpatient records, pathology reports, and radiotherapy records.

Materials and methods

Astrocytomas were classified as Grade IV when the criteria described by Kernohan and Sayre (3) were met. These tumors are highly cellular and pleomorphic with increased mitoses, coagulation necrosis, and vascular proliferation.

All histopathological reports were reviewed to ensure a high level of specificity, and if there was any doubt, the microscopic sections were re-examined. In addition, specimens from patients who survived 24 months or more were re-examined to confirm that low grade astrocytoma had not been included in error.

Information was obtained on each patient's age, gender, symptoms, duration of symptoms, tumor location, radiation dosage (if radiotherapy was received), and survival (months). Treatments were classified into the four categories of complete resection only; complete resection plus radiotherapy; incomplete resection alone; and incomplete resection plus radiotherapy. The degree of resection was defined by the neurosurgeon's impression of the amount of tumor removed at the time of operation. Patients who underwent reoperation were excluded.

The confirmed Grade IV astrocytomas were distributed by tumor location as follows: frontal lobe 36.5%; parietal lobe 30.6%; temporal lobe 28.5%; and occipital lobe 4.4%.

Survival data were recorded as the length of time from diagnosis to death. The statistical end point of this study was survival. Differences in survival were tested using the log rank statistics. Multivariate analysis of the various prognostic factors was determined by Stepwise Cox proportional hazards model analysis.

Results

The study sample was comprised of 80 males (58%) and 58 females (42%). The median age at diagnosis was 59 years (range 21 to 87 years).

Headaches, motor weakness, nausea and vomiting, and confusion were the most common presenting symptoms (Table 1). Only one patient was asymptomatic at presentation. The symptoms lasted less than one month in 57 patients, 1-3 months in 30 patients; 3-6 months in 28 patients; 6-12 months in eight patients; and greater than 12 months in 15 patients.

All patients had craniotomies. Of these patients, 73 underwent total resection, 62 had subtotal presection

Table 1. Presenting Symptoms of the 138 Patients at CAMC With Glioblastoma Multiforme

Presenting Symptoms	Number of Patients	Percentage of Patients
Headaches	90	51%
Motor Weakness	88	50%
Confusion/Memory Loss	64	36%
Dizziness/Gait Problems	52	29%
Speech Problems	45	25%
Seizures	31	17.5%
Sensory Symptoms (pain paresthesias)	31	17.5%
Hallucinations	4	3
Dysphagia	2	1
Unknown	2	1
Asymptomatic	1	0.5%
Weakness (extremity, hemiparesis)	84	47.5%
Hyper/Hyporeflexia	47	26.5%
Confusion	47	26.5%
Speech Problems (aphasia, dysphasia)	37	21%
Positive Babinski	35	20%
Facial Weakness	30	17%
Sensory Loss	30	17%
Cranial Nerve Signs	29	16.5%
Visual Problems	27	15%
Papilledema	15	8.5%

and 3 underwent biopsies (Table 2). Sixty patients were given radiotherapy, and 50 of these individuals (80%) received at least 5,000 cGy (total dose). Of the 138 patients, 33 (24%) were treated by complete resection plus 40 (29%) by complete resection only; 26 (19%) by incomplete resection alone; and 3 (2%) by biopsy only. Only 11 patients received chemotherapy.

As shown in Table 3, treatment varied by the period of diagnosis - - the more recent the diagnosis the greater was the use of radiotherapy in association with craniotomy. There was also a difference in treatment by age, with patients ages 70 years or older less likely to receive radiotherapy compared to those less than 70 years (Table 4).

The median survival for all patients was 7 months (range: 0-36 months).

Table 2. Treatments Procedures Utilized for the 138 Patients

Treatment	# of Patients	% of Patients
Complete Resection	40	29.0%
Complete Resection/Radiotherapy	33	23.9%
Incomplete Resection	36	26.1%
Incomplete Resection/Radiotherapy	26	18.8%
Biopsy Only	3	2.2%

Twenty-seven patients (20%) survived at least one year, four of whom survived at least 24 months. There were no 5-year survivors. As shown in Table 5, patients who received radiotherapy after a complete resection had a significantly longer median survival than those who did not. The median survival times were 12 months and 4 months respectively ($p = .001$). Patients who received radiotherapy following an incomplete resection also had a significantly longer median survival than those who did not receive radiotherapy. The median survival times for these patients were 10 months and 3 months respectively ($p = .001$).

Table 3. Types of treatments utilized to treat glioblastoma multiforme by period of diagnosis.

Treatment	1966-1971 (N = 40)	1972-1977 (N = 36)	1978-1981 (N = 23)	1982-1986 (N = 36)
Complete Resection Only	17 (42.5%)	15 (42%)	4 (17%)	4 (11%)
Incomplete Resection Only	19 (47.5%)	12 (33%)	0 (0%)	4 (14%)
Complete Resection/Radiotherapy	1 (2.5%)	5 (14%)	10 (43%)	17 (47%)
Incomplete Resection/Radiotherapy	3 (7.5%)	4 (11%)	9 (40%)	10 (28%)

**Three patients received only biopsies*

Table 4. Types of treatments utilized to treat glioblastoma multiforme by age at diagnosis.**

Treatment	< 40 (N = 2)	40-54 (N = 36)	55-69 (N = 67)	> 70 (N = 30)
Complete Resection Only	0	33%	27%	35%
Incomplete Resection Only	0	27%	21%	38%
Complete Resection/Radiotherapy	50%	15%	36%	10%
Incomplete Resection/Radiotherapy	50%	25%	16%	17%

**Three patients received only biopies*

***Values indicate the percentages of the total number in each group*

Multivariate analysis of prognostic factors done by Stepwise Cox proportional hazards model analysis indicated that radiotherapy was the most significant predictor of survival (Figure 1). However, it was not a proportional hazard (Z:PH=4.34) as assumed for the Cox model. As a result, by stratifying on radiotherapy and excluding it from the initial model, the analysis was performed again. Then, age became a significant predictor with a hazard ratio of 1.34 for an increase of 20 years in age.

Twenty-seven patients survived for at least 12 months from the time of diagnosis. This cohort consisted of 17 males and 10 females with a median age of 55 years. The tumor was located in the frontal lobe in seven patients, in the temporal lobe in 8, in the occipital lobe in two, and in parietal lobe in 10 patients. All but three patients were given postoperative radiotherapy, and only three received chemotherapy.

Discussion

Caution must be taken when comparing the results of different studies of high grade astrocytoma because interpretation of these studies remains limited because:

1. The multiple histologic classifications used in categorizing these neoplasms, (3,4,5,6,7,8);
2. Differences in the way patients with tumors of varing histologic grades have been analyzed;
3. The frequent lack of a central pathological review process; and
4. The lack of adequate documentation of the surgical methods used to ensure adequacy of tissue specimens for diagnosis, particularly in a tumor aptly described as "multiforme" (4,15,16,17).

Until recently, the majority of studies (including the present one) that have addressed the role of surgery in the management of high-grade astrocytomas in adults have relied on the surgeon's "impression" of the degree of resection accomplished. The imprecision of such estimates has been amply demonstrated and may be expected, given the infiltrative natures of these tumors.

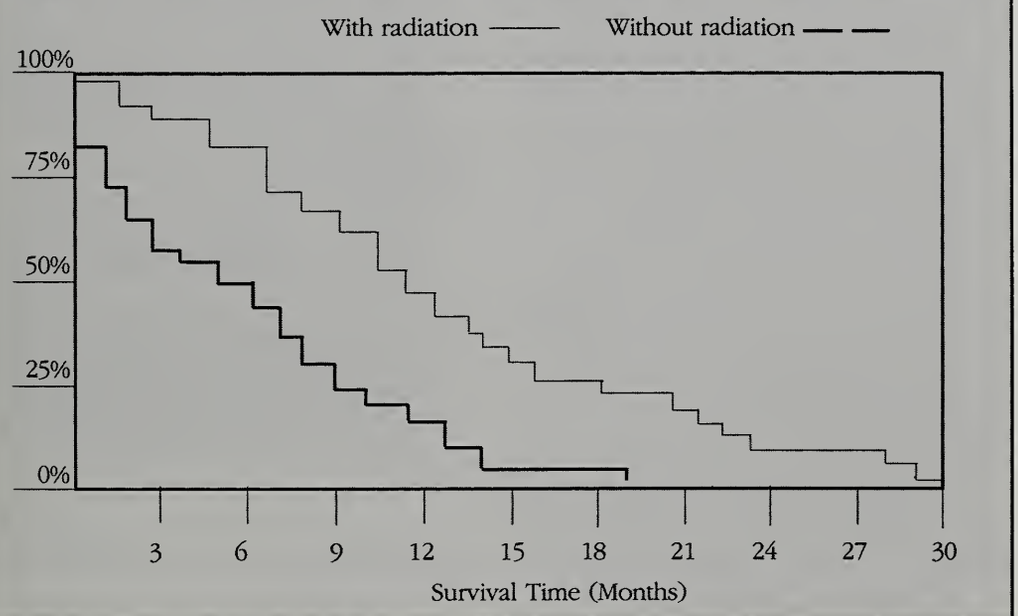
Most of these studies retrospectively review the records of patients who were operated on by different surgeons (18,19,20,21). One surgeon's "total resection" may represent another's "subtotal" resection. Some investigators have recently suggested that CT scanning or gadolinium-enhanced MR imaging may more clearly define the extent of tumor reduction. However, gadolinium does not cross an intact blood brain barrier (BBB), and thus may not accurately

Table 5. Survival related to the extent of surgery/radiotherapy.

Treatment	Median Survival	95% C.I.*
Complete Resection	4 Months	2-6
Complete Resection/Radiotherapy	12 Months	10-13
Incomplete Resection	3 Months	1-7
Incomplete Resection/Radiotherapy	10 Months	7-14

**Confidence Interval*

Figure 1. Survival curves (radiation versus no radiation).



identify tumor cells in brain regions distant from the site of increased BBB permeability (22). In the few CT-based studies available, there is no consistency in the methods of estimating residual tumor volume or in the timing of the postoperative radiographic studies.

The Kernohan grading system (3) was used in our study rather than the more recent three-tier system (25), so that we could compare our results with those of previous studies. Since necrosis is the key feature used to separate glioblastoma multiforme from anaplastic astrocytoma in the three-tier system, the patients in our study classified as having a Kernohan Grade IV tumor (many of whom had signs of tumor necrosis), would have corresponded with a glioblastoma classification in the Kernohan system and in the three-tier system as well.

The median survival rates in our series are similar to those reported by Slaford and colleagues (1) and Walker et al (2). There were no 5-year survivors in our series as compared to the 5-year survival for glioblastoma multiforme of 5.5% in the American College of Surgeons' National Survey of Patterns of Care for Brain Tumor Patients (26). The negative association between age and survival in this series is consistent with other series (27,28,29). Whereas 33% of patients under age 40 and 22% between ages 40-55 survived one year or more, this proportion was 17% for patients age 70 years or more. In our multivariate analysis of factors which predict survival, after stratifying for radiotherapy and excluding it from the analysis, age was the most significant with a p value of .037. The poorer one-year survival rate in those age 70 years or older may be partly due to the smaller percentage who received postoperative radiotherapy as indicated in Table 4.

The clinical functional ability of the brain-tumor patient at the time of treatment is known to be a strong predictor of outcome. Since Karnofsky function rating scores were unavailable for most of our cases, we were unable to determine whether the patients aged 70 years or older were selected for the least aggressive therapy (i.e. surgery alone) due to poor performance status (i.e. a lower Karnofsky rating) at presentation.

The increasing use of radiotherapy from 1978-1986 after surgery reflects a more general international response to the evidence from clinical trials that radiotherapy, while not curative, may enhance survival in the short term. Patients treated by both surgery/radiotherapy had a longer median survival than other patients in this series. However, the effect of patient selection on this outcome could not be quantified in the absence of randomized controls.

It is clear that glioblastoma multiforme continues to have an extremely high case fatality rate. Although there was a trend towards an increased use of radiotherapy, the overall long-term survival rate was poor. Only four patients in this series survived two years or more, and there were no 5-year survivors.

Despite the significant clinical advances of the past 10-15 years, no impact on the natural history of high-grade astrocytoma has yet been felt. Surgery followed by radiotherapy remains the standard treatment, with a small potential increment in the "tail of survival curves gained through the use of adjuvant nitrosoureas" (2). The use of interstitial brachytherapy, radiosurgery, systemic and/or local therapy with biologic response modifiers, in-vitro drug sensitivity screening of cultured tumor cells, and/or hyperosmotic agents, are all innovative approaches currently under investigation. It is hoped that the present dismal prognosis of these tumors may improve with further progress in these studies.

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Diagnosing and treating congenital melanocytic nevus simulating malignant melanoma

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Abstract

Many cases reported as malignant melanomas arising in benign congenital melanocytic nevi in the neonatal period have not shown evidence of metastases after several years of follow-up. These lesions were probably pathologically misdiagnosed, thus creating a controversy regarding the precise incidence. This article describes the case of an infant with a giant melanocytic nevus simulating malignant melanoma to illustrate the proper criteria for diagnosis of this condition so extensive and unnecess therapy procedures can be avoided.

Introduction

Congenital melanocytic nevi early in life and recurrent nevi may have a pattern of atypical melanocytic hyperplasia described in malignant melanoma of the superficial spreading type (1). These lesions are not biologically malignant; however, histologically they may simulate a malignant melanoma (2).

This articles describes a case of congenital melanocytic nevus simulating malignant melanoma and reports on the difficulties in diagnosing and treating this condition. Histopathologic markers for the correct diagnosis are also presented.

Case report

A white male was born with a 10 x 5 cm elevated pigmented lesion on his left buttocks (Figure 1). When this baby was two and a half months old, a diagnostic punch biopsy was performed because this lesion seemed to be getting darker and the parents were concerned. The punch biopsy was thought to be compatible with a benign congenital nevus, but some pagetoid appearing melanocytes were noted in the epidermis (Figure 2).

Figure 1. The large, elevated, pigmented, congenital melanocytic nevus on the infant's left buttock.

The parents were told that this lesion was benign, and that excision with a narrow margin would be sufficient. Primary closure was made possible by means of intraoperative tissue expansion (Figures 3a,3b).

Upon submission of the excised specimen for pathological studies, the preliminary report favored malignant melanoma occurring in a congenital nevus (Figures 4a,4b). Due to the discrepancies of the histological interpretations of the initial incisional and the definitive excisional biopsy, several other specialists in plastic surgery and dermatology were consulted. There was a consensus of opinion that the lesion was a benign congenital nevus simulating a malignant melanoma.

This patient has been followed regularly for the past six years, and there has been no indication of malignancy (Figure 5).

Histologic criteria

The following microscopic features can simulate a malignant melanoma in a benign congenital nevus:

1. Discrete nests of pigmented melanocytes at all levels of the epidermis (3,4,5);
2. Atypical melanocytic proliferation hugging the dermal-epidermal junction (5);
3. Lentiginous epidermal hyperplasia (6);
4. Pagetoid melanocytic proliferation (5);
5. Individually displaced large melanocytes within the epidermis (3); and
6. Loosely cohesive nests of melanocytes with a "balloon cell appearance" may be prominent in the papillary dermis (5).

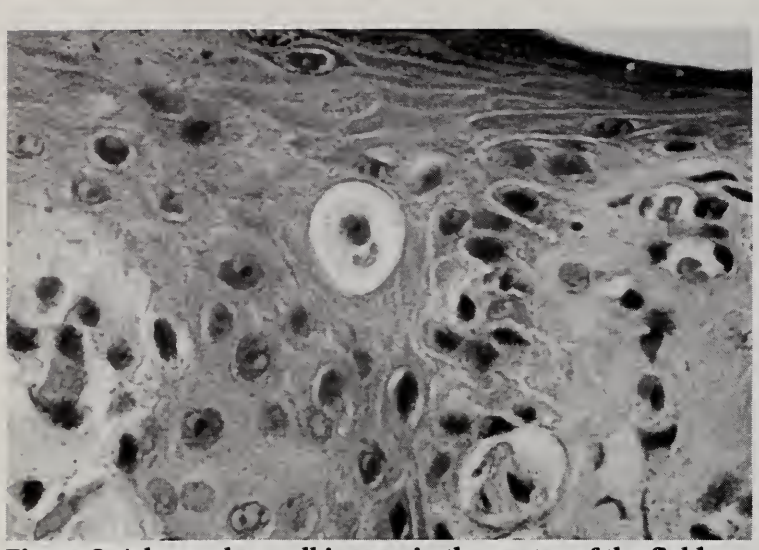

Figure 2. A large clear cell is seen in the center of the field representing an example of a pagetoid melanocyte from the original punch biopsy.

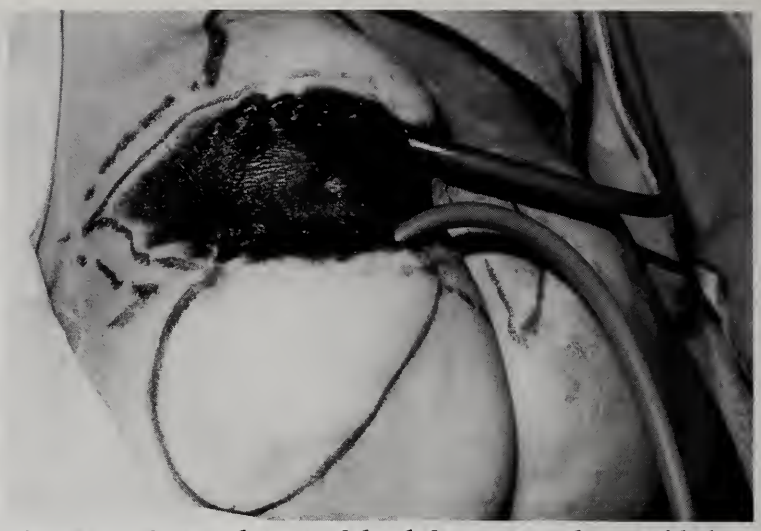

Figure 3. Primary closure of the defect was made possible by means of intraoperative tissue expansion with two Folley catheters prior to the excisional biopsy.

The crucial clues to the correct diagnosis of a biopsy specimen of congenital melanocytic nevus excised shortly after birth are:

1. Splaying of nevus cells between collagen bundles in the reticular dermis and the adnexocentric arrangement of nevus cells. These features are characteristic and specific for congenital melanocytic nevus (5).

2. Melanocytes within the epidermis that do not have atypical nuclei. The nuclei may be large, but they are not pleomorphic (7).

3. Typical nevus cells within the epidermis lack apparent potential for dermal invasion (8).

4. No host response/regression (8).

5. Contiguous rather than random basal melanocytic hyperplasia occurs (8).

6. Ballooned cells of nevi are situated mostly in nests and at the dermal-epidermal junction. The cells are typical and not in mitosis (8).

7. Pagetoid cells are rather small with round banal nucleui (8). In a malignant melanoma, pagetoid cells are scattered throughout the epidermis, and this does not occur in melanocytic nevi with pagetoid nevus cells. Atypical cells are rare.

8. Symmetrical changes (7).

9. Clusters of intraepidermal melanocytes outnumber existing individual intraepidermal melanocytes (7).

Discussion

The potential risks of a congenital melanocytic nevus (CMN) being a precursor to malignant melanoma have led to special considerations in treatment strategies. The lifetime risk of malignant degeneration of large congenital nevi is about 6.3% (9).

The intraepidermal melanocytic component of congenital melanocytic nevi may appear identical to the malignant melanoma, but such lesions may mature with age (4). These lesions rarely show progressive growth or behavioral characteristics of melanoma (10). There are atypical varieties of congenital melanocytic nevi, with microscopic features intermediate between benign and malignant. This may be analogous to acquired dysplastic nevi (9).

Due to atypical histological findings in some of these CMNs, only metastatic melanomas should be considered when the incidence figures of melanomas arising in congenital nevi are quoted (11).

Our case scenario is not uncommon since patients with a questionably changing congenital nevus are often referred to have the lesion evaluated. Frequently, these these lesions appear to show no real evidence of being clinically malignant, but in fear of missing an early malignant melanoma, a punch or incisional biopsy is performed.

Histologically, it is customary for melanocytes to be located no higher than the basal layer of the epidermis in benign pigmented lesions. The initial biopsy revealed melanocytes higher up than the basal layer. This was of concern, but not diagnostic of malignant melanoma. As a result of these findings and the potential of congenital nevi to degenerate into malignant melanoma, excision of the lesion was recommended.

Several problems arose when the histopathological exam was thought to be compatible with melanoma. The parents were told initially that the lesion was benign, but it should be excised to prevent possible malignant degeneration. Would this infant now have to undergo a third procedure, since only narrow margins were obtained? If the lesion was suspected to be malignant, should the tissue expanders have been inserted within the margins of the lesion?

There have been reports of an overdiagnosis of malignant melanoma in association with congenital melanocytic nevi (3,12,13,14). Careful study of the histopathological criteria for differentiation will determine the proper diagnosis of such cases, therefore eliminating extensive and unneccessary resections.

Figure 4A. A biopsy section of the congenital melanocytic nevus displaying discrete nests of pigmented melanocytes, loosely cohesive nests with a "balloon cell appearance," and individually displaced large melanocytes.

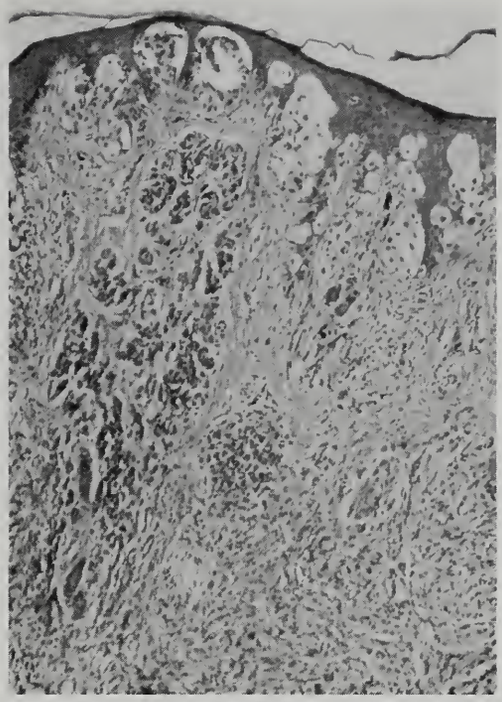

Figure 4B. A biopsy section of the congenital melanocytic nevus displaying discohesive nests, "balloon" or pagetoid cells, and individually displaced melanocytes.

Figure 5. Photograph of the patient's left buttock area four years after the excision.

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Spontaneous resolution of an isolated unilateral fetal pleural effusion: A case report

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Abstract

Isolated pleural effusion is rare and occurs when varying degrees of fluid surround the fetal lung without concomitant hydrops. This article reports a case in which spontaneous resolution of an isolated fetal pleural effusion occurred four weeks following the third trimester sonographic diagnosis, without any morbidity or mortality to the fetus or neonate. The diagnosis and possible complications associated with fetal pleural effusions are also discussed, as well as a proposal for management when confronted with this entity.

Introduction

The antenatal diagnosis of fetal pleural effusions by ultrasound is rare. There is an associated high perinatal mortality rate of up to 50% (1,2), with prematurity, pulmonary hypoplasia and progression to generalized fetal hydrops being the major contributors. Occasionally spontaneous in-utero resolution has been described, with survival in all reported cases (3).

This article presents a case where the effusion spontaneously resolved four weeks after in-utero diagnosis, and proposes an algorithm for managing this uncommon condition.

Case Report

A 24-year-old nulliparous woman had an uncomplicated pregnancy, until an ultrasound performed at 35 weeks gestation for size-date discrepancy, revealed a small amount of fluid surrounding the right lung. The lung demonstrated normal echotexture and contour.

There was no evidence of other intrathoracic pathology, fetal anomalies or hydrops, and the amniotic fluid volume was normal. The maternal blood type was O Rh positive, with a negative antibody screen. A serologic test for syphilis was non-reactive.

An ultrasound two weeks later revealed no change in the effusion and no signs of fetal hydrops, namely skin edema, pericardial effusion, ascites or placental thickening. A fetal echocardiogram showed a normal heart with sinus rhythm and no evidence of tachyarrythmias. The patient refused amniocentesis for karyotype, and TORCH and Parvo virus IgM titers were ordered but not obtained by the patient.

A follow-up sonographic exam at 39 weeks revealed almost complete resolution of the pleural effusion, and one week later, the patient went into labor and spontaneously delivered a male infant weighing 4309 gms, with Apgar scores of 7 and 8 at 1 and 5 minutes respectively. A chest roentgenogram performed on the neonate failed to reveal any pleural effusion.

The mother and infant had an unremarkable hospital stay and were both discharged two days later.

Discussion

The incidence of an isolated fetal pleural effusion is unknown, but has been estimated to occur once per 15,000 pregnancies (2). The pleural effusion is described as mild if a small rim of fluid surrounds the fetal lung as was the case in our patient, moderate if the fluid surrounding the lung fills less than half of the hemithorax, and severe if the pleural fluid fills more than half of the hemithorax, and/or there is a mediastinal shift (4).

Pleural effusions are usually associated with non-immune hydrops; however, they can occur alone. In a study by Hagay et al of 82 cases of isolated fetal pleural effusion at initial diagnosis, only 9% resolved spontaneously and the other cases progressively developed into generalized hydrops (5). This study, though, included fetuses with congenital heart defects and various intrathoracic abnormalities including two cases of extra-lobar pulmonary sequestration, two cases of pulmonary lymphangiectasia, one case of diaphragmatic hernia and four cases of Down syndrome. Therefore, an isolated pleural effusion may represent an early stage in the development of fetal hydrops (5).

More commonly, isolated effusions are secondary to congenital chylothorax, diagnosed by analysis of the fluid from thoracocentesis, which shows lymphocytosis and a protein content close to that of plasma. Other causes may include intrauterine

infections (6) and diaphragmatic hernia (7). When pleural fluid accumulates, it may result in lung compression and lead to pulmonary hypoplasia and impaired venous return secondary to a shift in the mediastinum, causing congestive heart failure and hydrops fetalis (8,9). The latter predicts a grave prognosis (3).

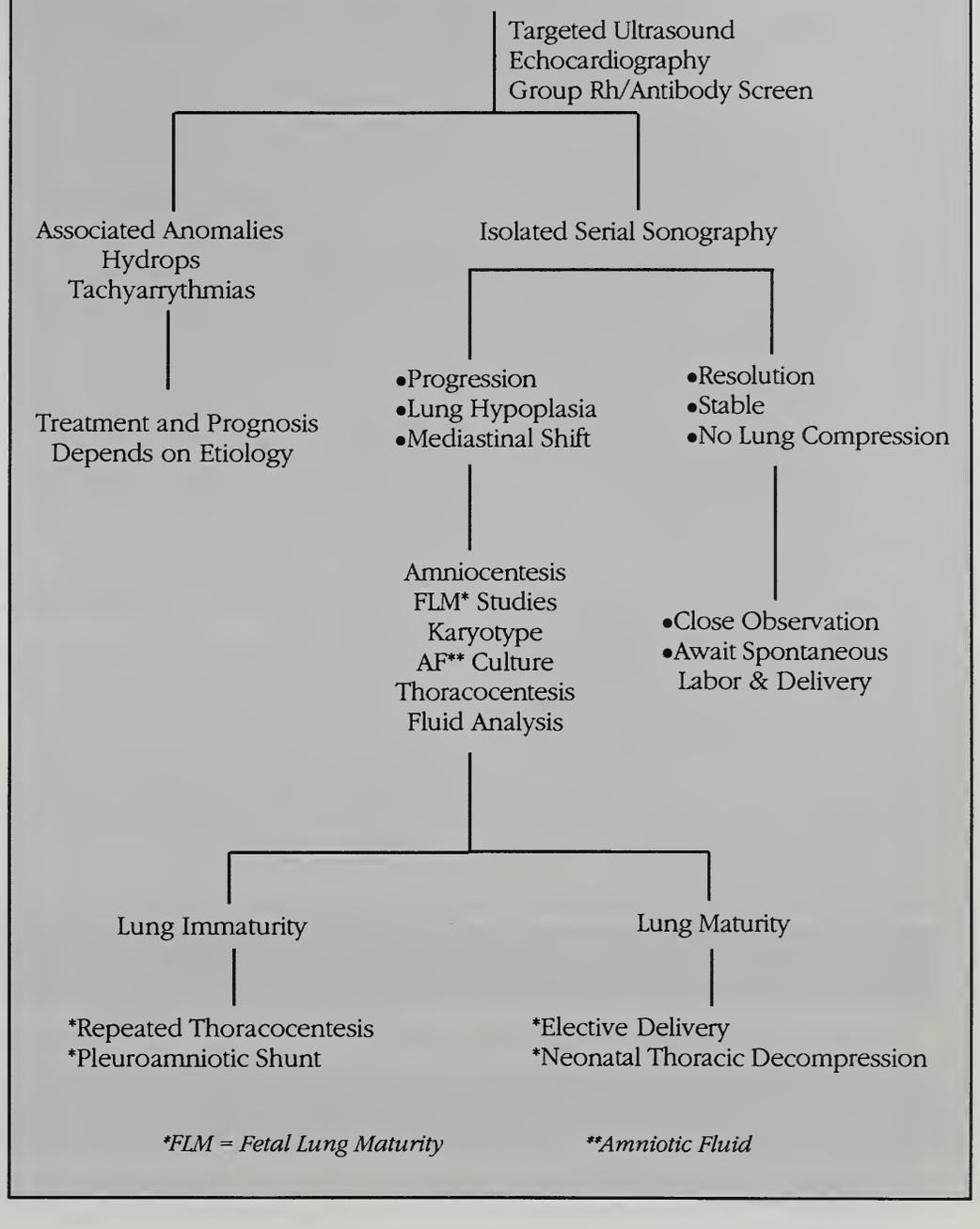
The sonographic diagnosis of a fetal pleural effusion should be considered when an echo-free area is seen between the lung, chest wall and an intact diaphragm (10). Polyhydramnios, a common associated finding, may be due either to decreased fetal swallowing or excessive transudation of fluid by the compressed lung. While some authors noted that polyhydramnios is of no prognostic value in cases with isolated fetal pleural effusion (2,3), Estroff and colleagues have shown that the prognosis is worse if accompanied by polyhydramnios (4).

Once the diagnosis is made, a detailed sonographic search for associated fetal anomalies, mainly intrathoracic, is indicated. A fetal echocardiogram will help evaluate for congenital heart defects and/or arrhythmias. Serial ultrasounds should then be performed every two weeks to assess pleural fluid volume. If the fluid remains the same or increases and antenatal in-utero intervention is entertained, further evaluation is warranted (5).

Amniocentesis should be done for karyotype determination because of the association between fetal pleural effusion and trisomy 21 (11,12). An ultrasound-directed fetal thoracocentesis can be performed at the same time and pleural fluid sent for viral and bacterial cultures (6,13,14), as well as biochemical and cell analysis.

In cases such as ours, spontaneous resolution of the pleural effusion occurs in four to five weeks after the diagnosis. In a study of 11 cases of fetal hydrothorax, in the absence of invasive fetal intervention, six of eight fetuses (75%) with isolated, unilateral hydrothorax, identified between 14 and 34 week's gestation, had spontaneous resolution of the pleural effusion, independent of the degree of hydrothorax and with a normal neonatal outcome (4).

Figure 1. Suggested Algorithm Plan for Fetal Pleural Effusion



In cases where resolution fails to occur, delivery is indicated if fetal pulmonary maturity is confirmed, with immediate neonatal thoracic decompression in mind. Since the mode of delivery does not appear to influence neonatal outcome (3), labor and vaginal delivery should be anticipated and C-section reserved for obstetric indications. If the fetus is far from term and there is progression of the pleural fluid, in-utero pleural decompression should be strongly considered to prevent extensive pulmonary hypoplasia. In-utero pleural decompression at term may prevent fetal hemodynamic compromise and ominous cardiotocographic findings as has been described by Mandelbrot (1) and life-threatening neonatal respiratory distress.

Fetal thoracocentesis, though, has been described with unsuccessful outcome (9) and worse with intrauterine fetal demise secondary to umbilical torsion (2). A meta-analysis for prognostic indicators done by Weber and Philipson noted that antenatal therapy was associated with a good outcome; while Hagay et al concluded that there is not enough data to support either expectant management or intrauterine

intervention in cases of isolated fetal pleural effusion diagnosed antenatally (3,5).

Both repeated thoracocentesis and/or pleuroamniotic shunting have been helpful, allowing normal lung expansion, facilitating ventilation of the neonate and improving postnatal respiratory function. In-utero shunting is most likely indicated when the pleural fluid increases early in gestation, with evidence of lung compression, since this procedure theoretically ensures continuous drainage, as opposed to the short-lasting benefit of thoracocentesis, where fluid may reaccumulate rapidly.

Conclusion

As a result of our experience and literature review, we propose the algorithm plan illustrated in Figure 1 to manage patients initially identified as having a fetal pleural effusion.

We also conclude that the identification of an isolated fetal pleural effusion on sonography maybe an early sign of fetal hydrops. However, since there is a strong potential for spontaneous resolution, especially when diagnosed in the third trimester, close observation with serial sonographic evaluations is warranted and invasive in-utero intervention with its potential complications must be individualized.

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Rapid microscopic detection of cytomegalovirus and PCP in brochoalveolar lavage specimens

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Abstract

This article describes how bronchoalveolar lavage specimens can be screened rapidly and inexpensively for Pneumocystis carinii and cytomegalovirus infections with materials available in any hospital laboratory.

Introduction

One of the growing uses of bronchoalveolar lavage (BAL) is to diagnose infectious diseases. It has been particularly useful in diagnosis of Pneumocystis carinii pneumonia (PCP) in the growing numbers of immunosuppresed patients.

Immunoperoxidase and traditional techniques such as silver stains can be particularly helpful in this regard, but are time consuming.

Methods

BAL is performed through the suction channel of a flexible bronchoscope.

The first step is to instill and aspirate two or three 20 ml aliquots of nonbacteriostatic 0.9% saline at room temperature into sterile suction traps until approximately 30 ml is retrieved. BAL samples should then be mixed and divided into two specimens of equal volume. One of these should be submitted to the microbiology laboratory for bacterial, fungal, and viral cultures, and the other aliquot needs to be submitted to the hematology laboratory for cell count, differential, and staining.

In the hematology section, conventional Wright staining is performed on cytospin preparations on the automated blood cell stainer. Gram and Calcofluor White stains are also routinely performed; Gomori methenamine-silver, acid fast, and Papanicolaou stains may also be performed.

Discussion

Wright (Romanovsky-type, i.e., eosin-methylene blue) stained cytospin preparations can provide an alternative means of diagnosing PCP, and as we have discovered, cytomegalovirus (CMV) infections. This method has the advantage of being both rapid and inexpensive.

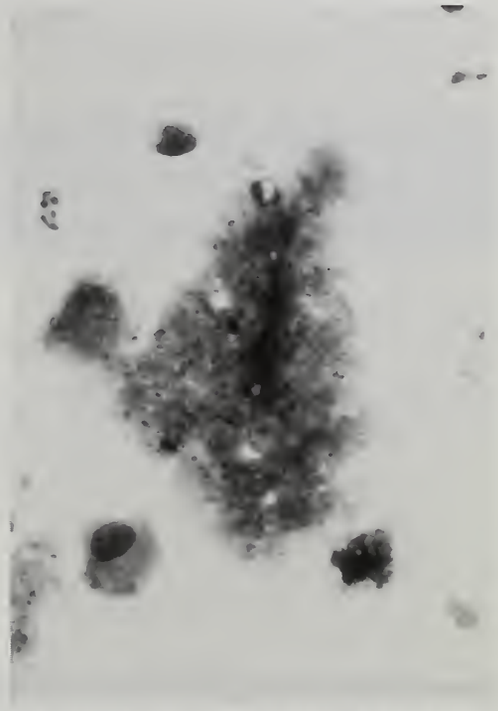

Figure 1. Frothy alveolar exudates of PCP appear as basophilic masses on Wright-stained preparations. Trophozoites of Pneumocystis appear in these masses as minute eosinophilic dots.

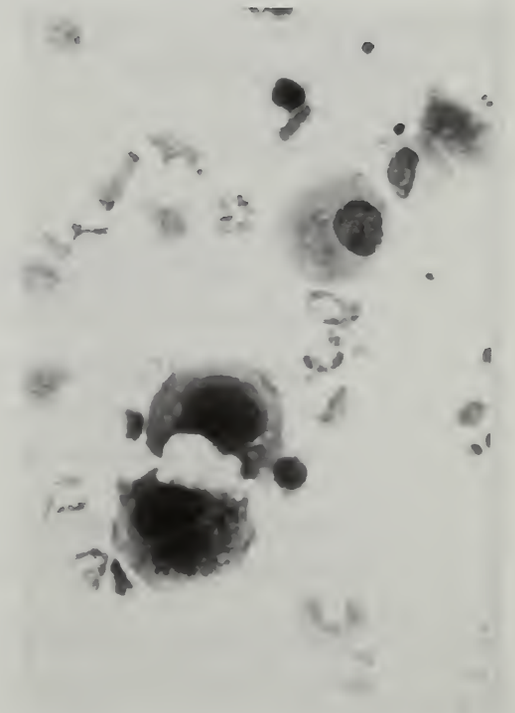

Figure 2. Two CMV-infected pneumoyctes with enlarged nuclei, central basophilic inclusions and marginalized chromatin. The lower left cell contains granular basophilic material.

In immunocompromised patients, CMV and PCP infections may co-exist. This is especially true of AIDS patients where it has been reported 30% of the time. Since these Wright stained preparations can be made and screened in a few minutes, they are very helpful in the evenings and on weekends, when staffing is limited. If the Wright stained preparations are diagnostic, the more time consuming and expensive studies may not be necessary.

PCP produces frothy alveolar exudates which appear on Wright stained preparations as basophilic masses. Trophozoites of Pneumocystis appear in these masses as minute eosinophilic dots (Figure 1). Color illustrations of this are cytopathology readily available (1).

In CMV pneumonia, pneumocytes and columnar cells of bronchial epithelium may be infected (2). Infected pneumocytes, if not degenerated, may be recognized on Wright stained specimens. Their nuclei are enlarged. Large, centrally located basophilic inclusions displace blue-gray chromatin to a narrow rim around the periphery of the nucleus (Figure 2). The halo so typically seen around the inclusion in Papanicolaou and Hematoxylin/ Eosin stains is not seen with the Wright stain.

We have had several recent cases of immunosuppressed patients where diagnosis and management was significantly impacted upon using rapid, readily available inexpensive stains. We encourage others to utilize and expand this microscopic screening technique, recognizing the potential microscopic detection of two emerging pathogens, Pneumocystis carinii and cytomegalovirus.

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This affiliation is yet another step we have taken in committing Simpson & Osborne to providing high quality health care services to the medical community in West Virginia.

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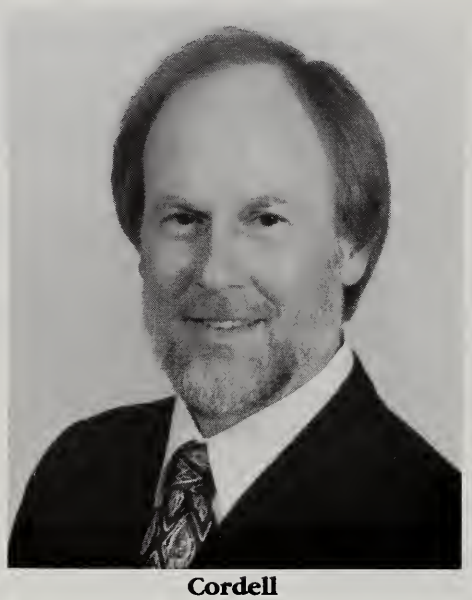
Cordell to be installed as WVSMA president

Charleston radiologist Ronald E. "Gene" Cordell, M.D., will take the presidential oath of office on Saturday, August 24, during the WVSMA's 129th Annual Meeting at The Greenbrier.

A native of Nashville, Dr. Cordell received his M.D. in 1975 from the University of Tennessee College of Medicine in Memphis, where he also studied pediatrics and completed a residency in radiology. In 1981, Dr. Cordell moved to Charleston to join the private practice of Associated Radiologists, Inc.

A fellow of the American College of Radiology, Dr. Cordell has a Certificate of Added Qualifications in Angiography and Interventional Radiology. He is an active staff member at the Charleston Area Medical Center, where he served as chief of the Department of Medical Imaging and Radiation Oncology from 1986-88. In addition, Dr. Cordell is a clinical professor of radiology at the Robert C. Byrd Health Sciences Center, Charleston Division, and he is a consulting physician at Boone Memorial Hospital, Braxton County Memorial Hospital, the Eye and Ear Clinic of Charleston, and Highland Hospital.



Cordell

Dr. Cordell has served on the WVSMA's Legislative Committee since 1991, and was chair of its Subcommittee to Evaluate Health Care Policy which was responsible for writing health care legislation from 1992-94. In addition, Dr. Cordell has been a member of the WVSMA's Constitution and Bylaws Committee for the past three years, and was elected vice president of the WVSMA in 1994, and president-elect in 1995.

A member of several other professional organizations, Dr. Cordell was president of Kanawha Medical Society in 1994 and 1995, and was secretary-treasurer of the West Virginia Radiological Society from 1991-95. He recently served as a radiology representative for the RBRVS Technical Advisory Panel for PEIA, Worker's Compensation and the West Virginia Medicaid Program.

Dr. Cordell and his wife, Joann, have two children, Chad and Andrea. The Cordells are very active members of Christ Church United Methodist, where Dr. Cordell has served as board member and an assistant scoutmaster.

New Alliance leaders to take office at convention

In conjunction with the WVSMA's Annual Meeting, the WVSMA Alliance will conduct its Annual Meeting August 23-24 at The Greenbrier.

In addition to the business and recreational activities which are planned, this year's meeting will feature a special luncheon and a silent art auction to raise funds for AMA-ERF. These events are described in more detail on page 223.

WVSMAA President Linda Elliott will preside over the convention meetings, and at the conclusion of the Second Session of the House of Delegates, AMAA President-Elect Johnnie Amonette will deliver the oath of office to the new WVSMAA President Amy Ricard of Huntington. The other officers to be installed are Kathy Fortunato, president-elect; Janet Sebert, vice president; Jerry Crites, treasurer; Rose Romero, Southeast regional director; Ginny Reisenweber, Northeast regional director; Jo Hannah Rorrer, Southwest regional director; Delia Naranjo, Northwest regional director. Maureen Ibrahim was installed last year as treasurer.

Ricard

Mrs. Ricard is a native of Wooster, Ohio, who obtained her B.A. degree in special education from Marshall University in Huntington.

(Continued on page 202)

1996 WVSMA Annual Meeting Highlights

August 21-24, 1996

Tuesday, August 20

6 p.m.	**WVSMA Executive Committee Dinner/Business Meeting**

Wednesday, August 21

noon - 1:30 p.m.	**Executive Committee/Council Luncheon**
1:30 - 4:30 p.m.	**WVSMA Council Meeting**
6:30 - 7:30 p.m.	**Presidential Reception**

Thursday, August 22

7 - 8:30 a.m.	**WVSMA Medical Education Committee Breakfast Meeting**
9 a.m. - noon	**General Scientific Session** "Marfan's Syndrome" - Gordon F. Murray, MD "Interventional Cardiology: Promises Fulfilled?" - Kenneth M. Kent, MD "Office Evaluation of Children with Suspected Heart Disease" - William A. Neal, MD "Non-surgical Treatment of Heart Disease" - Stafford G. Warren, MD
noon - 1:30 p.m.	**Lunch and Learn** (limited space) "The Terminally Ill Patient: Is Physician-Assisted Death the Answer?" - Alvin H. Moss, MD AMA President and Other Visiting Dignitaries
2 p.m.	**Golf, Tennis, and Volleyball Tournaments**
4 p.m.	**1997 Annual Program Committee Meeting**
4:30 p.m.	**WESPAC Meeting**
6:30 - 7:30 p.m.	**Reception hosted by Medical Assurance of West Virginia and Acordia of West Virginia**

Friday, August 23

7 a.m.	**WVSMA Section on Surgery Breakfast Meeting**
7 a.m.	**Specialty Breakfast Meetings** (times and locations to be announced)
9:00 a.m.	**First Session of the House of Delegates**
	Thomas L. Harris Address - Gordon F. Murray, MD "Graduate Surgical Education - At Risk"
	WVSMA Presidential Address - James D. Helsley, MD
noon - 1:30 p.m.	**Lunch and Learn** (limited space) "Treatment with Controlled Substances -- How to Keep Your License" - Joseph H. Talley, MD AMA President and Other Visiting Dignitaries
noon	**Specialty Meetings** Various West Virginia Specialty Societies will be scheduled for luncheon/business and scientific meetings. Times and locations will be noted in the official program.
1:30 p.m.	**Resolutions Committee - Open Session**
6 - 7 p.m.	**Reception hosted by WVU/MU Schools of Medicine**
9:30 - 11 p.m.	**Jazzin' It Up! - Entertainment by WVU Jazz Ensemble**

Saturday, August 24

7:30 a.m.	**Specialty Breakfast Meetings** (times and locations to be announced)
9 a.m.	**Second Session of the WVSMA House of Delegates**
9:30 a.m.	AMA Presidential Address - Daniel H. Johnson Jr., MD Resolutions Election of Officers
10:15 - 11 a.m.	**E. B. Flink Address** - Joseph H. Talley, MD "Bugs & Drugs: An Antibiotic Selection Overview"
noon - 1:30 p.m.	**WVSMA Component and Specialty Society Presidents, Past Presidents, Visiting State Presidents and 50-Year Graduates Luncheon**
1:30 p.m.	**Reconvene Second Session of the House of Delegates** (business continued) Oath of Office and Presidential Address
4 - 5 p.m.*	**Reception Honoring Newly-Installed Officers of WVSMA and Alliance**

**Time dependent upon adjournment of House of Delegates' Session*

New Alliance leaders

(Continued from page 200)

After teaching emotionally disturbed teenagers at Huntington State Hospital for two years, Mrs. Ricard stayed home to raise her two daughters, Jacqueline and Raquel. For the past several years, she has been the office manager for her husband, Dr. Jose Ricard, who is a family practitioner and sports medicine specialist. She held this post until this summer when she resigned to devote her full attention to her Alliance duties.

Mrs. Ricard served as president of the Cabell County Alliance from 1993-94, and was WVSMAA vice president from 1994-95, and WVSMAA president-elect from 1995-96. She is a former board member for the Girl Scout Council and the Huntington Chamber Orchestra.

Dr. Mufson elected president of APM

Maurice A. Mufson, M.D., has been named president of the Association of Professors of Medicine (APM), the national organization of chairs of departments of internal medicine at the 125 U.S. medical schools and several of their affiliated teaching hospitals.

Dr. Mufson serves as professor and chair of the Department of Medicine at the Marshall University School of Medicine in Huntington, a position he has held since the MU School of Medicine opened in 1976. Prior to leading the faculty at Marshall, Dr. Mufson served as professor of medicine at the University of Illinois College of Medicine.

A native of New York, Dr. Mufson graduated from Bucknell University in Lewisburg, Pa., in 1953, and from the New York University School of Medicine in 1957.

UHC holds pathology seminar to raise funds for Health Access Clinic

Dr. Chinmay Datta presents a check for $28,000, the proceeds from the pathology seminar conducted by United Hospital Center, to Dr. Louis Ortenzio, founder of the Health Access Free Clinic in Clarksburg. Pictured with Drs. Datta and Ortenzio are WVSMAA member Subhra Datta who is a member of the board of directors of Health Access; Bruce Carter, president of UHC; Sharon Humphreys, C.M.S.C., manager of Medical Staff Services at UHC; and Leonara Dotson, a volunteer with the UHC Auxiliary.

The Third Annual Seminar in Pathology, a fund-raising CME event which is sponsored each year by United Hospital Center (UHC) of Clarksburg, raised $28,000 for the Health Access Free Clinic in Clarksburg. This unique seminar was directed and organized by Dr. Chinmay K. Datta, a pathologist at UHC, and held at the Sheraton Station Square Hotel in Pittsburgh May 2-5.

Health Access Free Clinic was established in August 1992 by Dr. Louis Ortenzio, a local family physician, and it provides care primarily for adults 18 years and older. In most cases, patients are employed in minimum wage jobs or other jobs where health benefits are not available, or they have a pre-existing condition or other health problem that exclude them from insurance. The clinic cares for about 30 patients a day and provides about $4 million in total care each year. It is supported by grants from the United Way, the state of West Virginia, private foundations, the Harrison County Medical Society, telethons and private contributions.

Each year the seminar has grown in attendance, and this year it was attended by 116 physicians and two cytotechnologists from 28 states. A portion of the registration fee was tax deductible as a charitable contribution.

Assisting Dr. Datta with the seminar were Sharon Humphreys, C.M.S.C., manager of Medical Staff Services at UHC; his wife, Subhra, who is a member of the WVSMAA and a board member of Health Access; Lenora Dotson, UHC Auxiliary volunteer; Suzanne Horner, director of Public Relations at UHC; and Denise Steffich, administrative secretary for UHC.

National HIV phone consultation offered

Free HIV information and case consultation is available to health care providers through the National HIV Telephone Consultation Service, "Warmline (800) 933-3413, which is based at San Francisco General Hospital. Faculty include physicians, pharmacists and nurse practitioners.

Research Day

The winners of the 1996 Research Day competition at the Robert C. Byrd Health Sciences Center of WVU, Charleston Division, in the category of original research were: First Place - Matt Walker, MSIII (far right) and Sharon Istfan, M.D. (fourth from left); Second Place - Bryan Richmond, M.D. (center); and Third Place - Susan Walker-Matthews, Psych intern (second from left). Dr. Istfan also won first place in the category of case presentation and Dr. Richmond placed third in this category. The second place winner for the case presentation category was Maria Caceres, M.D., who is pictured on the far left.

Geriatrics chair created at WVU in honor of Dr. Morgan

Through a bequest in her will and two charitable remainder trusts, Mrs. Grace Kinney Mead of Fairmont, has directed approximately $2.5 million to the WVU School of Medicine to establish the "Grace Kinney Mead Chair of Geriatrics in Honor of Dr. David Z. Morgan."

The Mead Chair of Geriatrics will support the teaching salary and scholarly activities of an internationally recognized medical doctor or research investigator. Dr. Morgan, who is now a retired professor of medicine for WVU and is an associate editor of the *West Virginia Medical Journal* cared for Mrs. Mead when she was a patient at WVU Hospitals.

17th Clinical Ophthalmology Conference set

The Seventeenth Annual Clinical Ophthalmology Conference sponsored by WVU's Department of Ophthalmology will take place September 27 at Lakeview Resort and Conference Center in Morgantown.

Featured speakers will be Thomas M. Aaberg Jr., M.D., who will be the Hutchinson Lecturer on retina and vitreous disease, and Gregory S. Kosmorksy, D.O., who will discuss neuro-ophthalmology.

To register, phone (304) 293-3757.

ACC plans seminar

"New Techniques and Concepts in *Cardiology"* is the title of the American College of Cardiology's conference which will be presented October 24-26 in Washington, D.C.

For details, phone (800) 253-4636, ext. 695.

Medical Meetings

August

21-24 - WVSMA's 129th Annual Meeting, White Sulphur Springs

September

4-7 - Surfaces in Biomaterials '96 (sponsored by Surfaces in Biomaterials Foundation), Phoenix

11 - Battelle's Technology Intelligence Program, Princeton, N.J.

5-11 - American College of Emergency Physicians, New Orleans

25 - 43rd Annual National Health Council's Forum, Washington, D.C.

26-28 - American Academy of Facial Plastic and Reconstructive Surgery, Washington, D.C.

26-28 - American Academy of Otolaryngic Allergy, Washington, D.C.

28-Oct. 4 - College of American Pathologists and the American Society of Clinical Pathology, San Diego

October

3-6 - American Academy of Family Physicians, New Orleans

4-8 - The Clinical Pharmacology of Anticancer Drugs (sponsored by Berlex Oncology Foundation), Leesburg, Va.

5-7 - Comprehensive Gynecology (sponsored by Berlex Oncology Foundation), New York City

9-13 - Infectious Disease Board Review Course (sponsored by Center for Bio-Medical Communications, Inc.), Washington, D.C.

20-25 - Ortho-Neuro Review (sponsored by MRI Educational Foundation, Inc.), Cincinnati

25-27 - Advances in Sonography (sponsored by Society of Radiologists in Ultrasound), San Francisco

27-31 - American College of Occupational and Environmental Medicine's 48th Annual State-of-the-Art Conference, Toronto

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- *"Office Evaluation of Children with Suspected Heart Disease,"* William A. Neal, MD
- *"Non-surgical Treatment of Heart Disease,"* Stafford G. Warren, MD
- *"Graduate Surgical Education - At Risk,"* ***T. L. Harris Address*** Gordon F. Murray, MD
- *"Bugs & Drugs - An Antibiotic Selection Overview,"* ***E. B. Flink Address*** Joseph H. Talley, MD

If you haven't registered for the WVSMA's 1996 Annual Meeting to be held at The Greenbrier, you will want to do so immediately. You won't find a better bargain anywhere with a registration fee of only $125 for members and $175 for non-members. For the registration fee, you get CME hours, four receptions, volleyball and sensational jazz entertainment.

Please be sure to make hotel reservations early by calling (800) 624-6070. For more information about other hotels in the area, contact the WVSMA at (304) 925-0342. For your convenience, you may register for the conference by calling the above number and using your Visa or MasterCard.

Tours of "The Bunker" will be available during the meeting. Publicly revealed recently that this facility was constructed to lodge the United States Congress and other ranking federal officials in case of a nuclear war or attack on the U.S. Please check with *The Greenbrier* for more details.

1996 WVSMA Annual Meeting

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Lunch & Learns	**(Thursday, Aug. 22)**		
	physician	$50	_____
"Physician-Assisted Death"	spouse/student	$35	_____
"Treatment with Controlled Substances -- How to Keep Your License"	**(Friday, Aug. 23)**		
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	spouse/student	$35	_____
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Jon Lipps, Julie Farriss, Doug Wallace

BOOTH # 48
Strategic Health Services, Inc., Home Care Divisions
Christy Walker

BOOTH # 49
Schering Oncology/Biotech
Diane Hackney Oliver

BOOTH # 50
The P.I.E. Mutual Insurance Co.
John Hall, Gerry Opgenorth

BOOTH # 51
Carelink
John Marks, Susan Cunningham, Tim Stalnaker, Barbara Good

Support Our Exhibitors!

Exhibits are an integral part of the Annual Meeting and become a valuable adjunct to the scientific program. The income from rental of exhibit space enhances our budget and allows us to offer you a top-notch, professional meeting, including the ability to attract a number of well-known speakers.

BOOTH # 52
West Virginia University - PET Center
Narsh Gupta, M.D., Sahar Alshallah, Jeff Foss

BOOTH #53
Acordia of West Virginia Association Group
Scott Atkins

BOOTH # 54
Marshall University School of Medicine
Gay Jackson, Beth Hammers

BOOTH # 56 & 57
Medical Assurance of WV, Inc. and Acordia of WV, Inc.
A. Derrill Crowe, M.D., Jim Cates, Chuck Ellzey, Steve Brown, Michele Myers, Rob Vass, Tim Rose, Tom Auman, Tamara Lively

Thanks!

Special appreciation goes to the following businesses, medical societies, and schools who have contributed educational grants or other support to this year's Annual Meeting. This support makes possible the educational emphasis and success of our meeting:

Acordia of West Virginia, Inc.

Chapman Printing Company

The Greenbrier Hotel

Kanawha County Medical Society

Marshall University School of Medicine

Monongalia County Medical Society

Oasis Pain Management Program

Sandoz Pharmaceutical

Smith, Cochran & Hicks, CPAs

West Virginia University School of Medicine

Wyeth Ayerst/A.H. Robins Company

WVSMA Annual Meeting Delegates & Alternates

BOONE (2) - ***Names not submitted***

BROOK (2)
DELEGATES: William T. Booher Jr., Joseph J. DePetro III
ALTERNATES: Rogelio L. Velarde, Leticia Velarde

CABELL (14)
DELEGATES: Robert Hess, G. William Lavery, Jose Ricard, Jack R. Steel, Phillip Stevens, D. H. Webb
ALTERNATES: Bill Echols

CENTRAL WV (4) - ***Names not submitted***

EASTERN PANHANDLE (4) - ***Names not submitted***

FAYETTE (3) - ***Names not submitted***

GREENBRIER VALLEY (4) - ***Names not submitted***

HANCOCK (3) - ***Names not submitted***

HARRISON (5)
DELEGATES: Craig Coonley, Cordell De La Pena, Erlinda De La Pena, Florencia Lopez, Douglas McKinney

ALTERNATES: Thomas Chang, Robert Hess, Mehmet V. Kalaycioglu, Carlos Naranjo

KANAWHA (19)
DELEGATES: Mark Ayoubi, Bruce Berry, Nicholas Cassis, Ronald Cordell, Alva Deardorff, Sandra Elliott, Michael Fidler, Michael Harris, Albert Heck, Lester Labus, Michael Lewis, Tony Majestro, Jimmie Mangus, Lee Neilan, Sam Oliver, Steve Perkins, William Sale, Elizabeth Spangler, Ralph Smith

ALTERNATES: Donald Farmer, Dante Geronilla, Reed Heywood, M. Z. Khan, Reginald McClung, Sam Newman, Tom Pearcy, David Ritchie, Robert Stone, John Willis

LOGAN (3)
DELEGATES: Rely C. Carbonel, Raymond Rushden, Rajendra Valiveti

MARION (4) - ***Names not submitted***

MARSHALL (2) - ***Names not submitted***

MASON (2) - ***Names not submitted***

MCDOWELL (2) - ***Names not submitted***

MERCER (5) - ***Names not submitted***

MONONGALIA (20)
DELEGATES: Paul L. Clausell, James D. Helsley, Jerome G. Johnson, John Pearson, Jeffrey A. Stead, Mary Ann Sens

OHIO (9)
DELEGATES: Robert Altmeyer, Terry Elliott, Michael Fortunato, Barton Hershfield, Dennis Niess, William Noble, Thomas Ream
ALTERNATES: Dennis Burech, Mary Nicholas Cater, Gary Kenamond, Rick Latos

PARKERSBURG ACADEMY (7) - ***Names not submitted***

POTOMAC VALLEY (2)

PRESTON (2)

PUTNAM (2)

RALEIGH (7)
DELEGATES: Anthony Dinh, Ahmed Faheem, Wallace Johnson, Carl Larson, Husam Nazer, William Scaring, Rajnikant Shah
ALTERNATES: Lewis Fox, Prospero Gogo, Carlos Lucero, Robert Pulliam, Iligino Salon, Norman Taylor, Nancy Webb

SOUTH BRANCH VALLEY (2)

SUMMERS (2)

TUG VALLEY (2)

TYGARTS VALLEY (4)
DELEGATES: Serge Cormier, Elvin Kreider, Joseph Tavolacci, Christopher Villaraza Jr.
ALTERNATES: Sam Krinsky, Stanley Masilamani, Joseph Noronha, Joung Rhee

WESTERN (2) - ***Names not submitted***

WETZEL (2)
DELEGATES: Donald A. Blum

WYOMING (2) - ***Names not submitted***

MEDICAL STUDENTS
DELEGATE: Melissa Matulis
ALTERNATE: Kristin DeHaven

Take The Opportunity To

Lunch & Learn

During The WVSMA's Annual Meeting At The Greenbrier

"The Terminally-Ill Patient: Is Physician-Assisted Death the Answer?

Alvin H. Moss, M.D. - Keynote Speaker
Thursday, August 22, 1996
noon - 1:30 p.m., Crystal Room

"Treatment with Controlled Substances -- How to Keep Your License"

Joseph H. Talley, M.D. - Keynote Speaker
Friday, August 23, 1996
noon - 1:30 p.m., Crystal Room

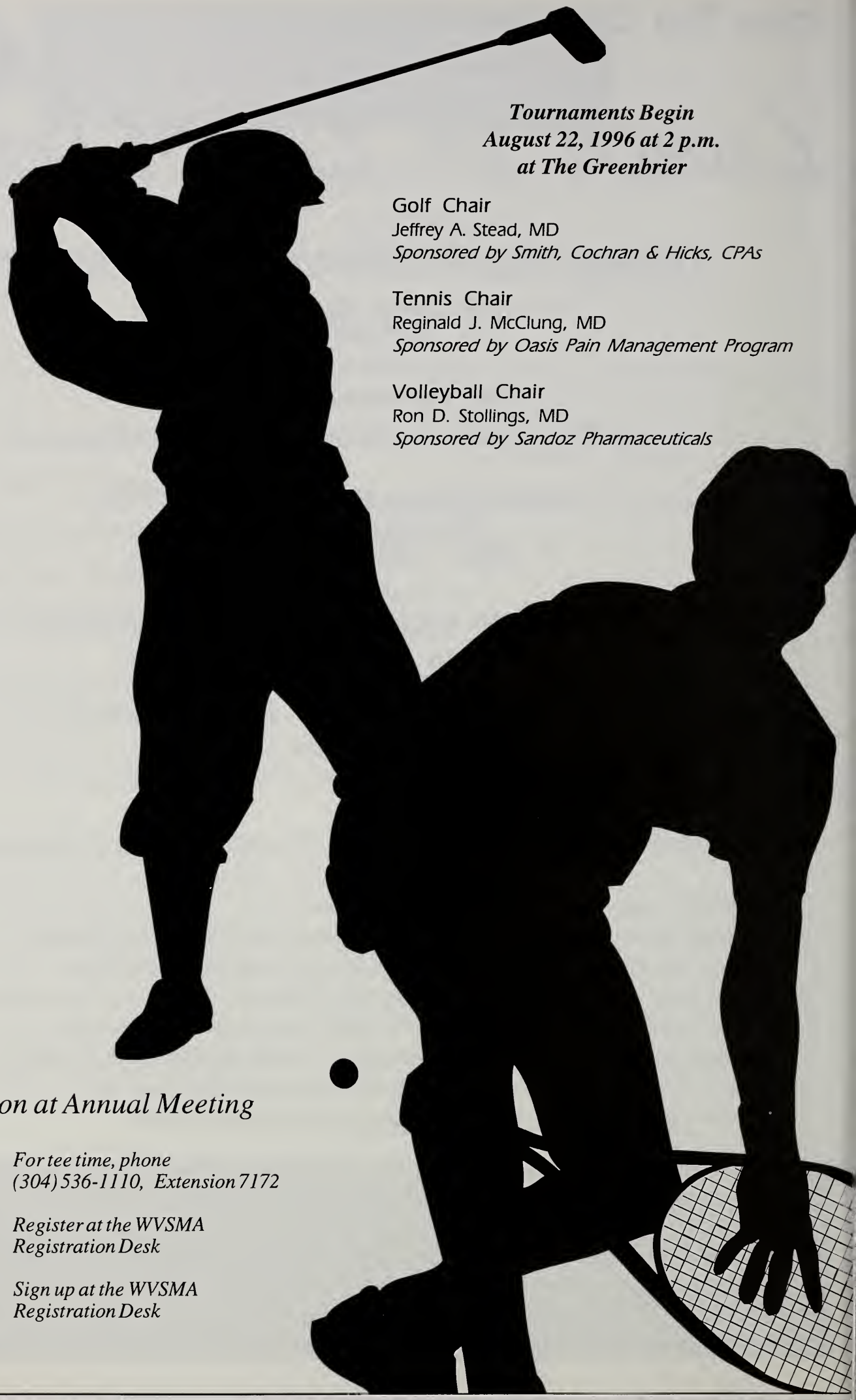
The following visiting dignitaries will be participating in these programs:

- **Daniel H. Johnson Jr., M.D., AMA President**
- **Jerome Melchior, M.D., President, Indiana State Medical Association**
- **Danny M. Clark, M.D., President, Kentucky Medical Association**
- **Alex Azar, M.D., President, Medical and Chirurgical Faculty of the State of Maryland**
- **John F. Kroner Jr., M.D., President, Ohio State Medical Association**
- **Jonathon E. Rhoades Jr., M.D., President, Pennsylvania Medical Society**
- **Ira D. Godwin, M.D., President, Medical Society of Virginia**
- **Sandra F. Olsen, M.D., President, Illinois State Medical Society**

Charleston Area Medical Center is accredited by the West Virginia State Medical Association to sponsor Continuing Medical Education to physicians.

These activities have each been approved for 1.5 credit hours in Category 1 of the Physician's Recognition Award of the AMA.[9]
The term of approval is January 1, 1996 to December 31, 1996 with option for renewal.

'96 WVSMA Tournaments



Tournaments Begin
August 22, 1996 at 2 p.m.
at The Greenbrier

Golf Chair
Jeffrey A. Stead, MD
Sponsored by Smith, Cochran & Hicks, CPAs

Tennis Chair
Reginald J. McClung, MD
Sponsored by Oasis Pain Management Program

Volleyball Chair
Ron D. Stollings, MD
Sponsored by Sandoz Pharmaceuticals

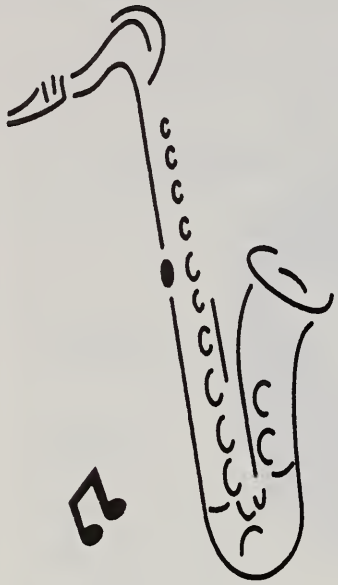
Registration at Annual Meeting

- *Golf -* *For tee time, phone (304) 536-1110, Extension 7172*
- *Tennis -* *Register at the WVSMA Registration Desk*
- *Volleyball -* *Sign up at the WVSMA Registration Desk*

WVSMA Component and Specialty Society Presidents,
Visiting State Presidents and
50-Year Medical School Graduates--

Your Presence is Requested
At A Special Luncheon
On Saturday, August 24 From Noon - 1:30 p.m.
At The Greenbrier During The WVSMA'S Annual Meeting

Please R.S.V.P. by phoning (304) 925-0342.



JAZZIN' IT UP!

Friday, August 23
from 9:30 to 11 p.m.
The Greenbrier

Cash Bar

Join us for an exciting evening of entertainment with a five-member, West Virginia University jazz ensemble featuring piano, saxophone, bass, drums and vocals. There will be lots of fun for everyone.

Special Thanks!!!

The WVSMA staff recognizes the members of this year's Annual Meeting Program Committee for the effort put forth by each individual. The time and initiative taken by these members is sincerely appreciated by the staff and all those who have the opportunity to participate in the Annual Meeting:

C. Vincent Townsend, M.D., Chairman

Constantino Y. Amores, M.D.
Janie Altmeyer, WVSMAA
John F. Brick, M.D.
Thomas H. Chang, M.D.
Ronald E. Cordell, M.D.
C. Richard Daniel, M.D.
Linda Elliott, WVSMAA President
Robert A. Gustafson, M.D.
James D. Helsley, M.D.
John D. Holloway, M.D.
Michael J. Lewis, M.D.
Alvin H. Moss, M.D.
Maurice A. Mufson, M.D.
Stephen L. Sebert, M.D.
Phillip R. Stevens, M.D.
Mabel M. Stevenson, M.D.

Ex-Officio Members

David Bailey, MBA
CME - Marshall Unversity

Kari Long
CME - WVU, Morgantown

Robin Rector
CME - WVU, Charleston

REMINDER

The West Virginia State Medical Association's Mid-Winter Seminars and Scientific Conferences are coming soon!

January 16-19, 1997
Charleston House - Holiday Inn
Charleston, WV

Mark These Dates!

Join us for:

- "Moving Points in Medicine"
- Physician/Public Session
- Lunch and Learn
- "Controversies in Medicine"
- "Potpourri of Topics"
- "New Challenges in Caring for the Chronically Ill"

CME Events

Charleston Area Medical Center - Charleston

August 24 & October 7
Pediatric Advanced Life Support - Recertification Course

September 20-21 & October 26-27
Pediatric Advanced Life Support - Provider Course

Robert C. Byrd HSC of WVU - Charleston

September 7
"5th Annual Appalachian Regional Neuro-rehabilitation Symposium"

September 12-14
"22nd Annual Hal Wanger Family Medicine Conference"

September 13-14
"Surgery Update 1996"

September 21
"Clinical PET Update - Euro-Suites Hotel, Morgantown"

October 4
"Complying with JCAHO Standards on Organizational Ethics" - Days Inn, Flatwoods

October 4-6
"Fall OB/GYN Women's Health Symposium" - Canaan Valley Resort, Davis

October 11
"Pediatric Oktoberfest '96"

October 17-18
"WV Conference on Aging - Canaan Valley Resort, Davis"

October 18
"The 7th Annual Microbiology One-Day Workshop"

October 25
"Fall Cancer Conference: Improving Quality of Life - A Goal of Cancer Care"

October 25-26
"Musulosketal Radiology Update"

October 29-30
"The Rural Health Conference" - Marriott Hotel, Charleston

WV State Medical Association - Charleston

August 21-24
WVSMA's 129th Annual Meeting - White Sulphur Springs

Area Outreach Programs

Sponsored by CAMC ◆ & Robert C. Byrd HSC of WVU ●

Fairmont

- ● Fairmont Clinic, October 16, 1 p.m. - "New Modalities in Contraception," Mark Gibson, M.D.
- ● Fairmont General Hospital, August 6, 7:30 p.m. - "Evaluation of a Child with Hematuria/Proteinuria," Dianne Muchant, M.D.

Man

- ◆ Man Appalachian Regional Hospital, August 22 - "Oral and Facial Lesions," Lee F. Allen, M.D., D.M.D., and David P. Wise, M.D., D.D.S.

Montgomery

- ◆ Montgomery General Hospital, August 9 - "Facial Trauma," Lee F. Allen, M.D., D.M.D., and David P. Wise, M.D., D.D.S.

Mineral Wells

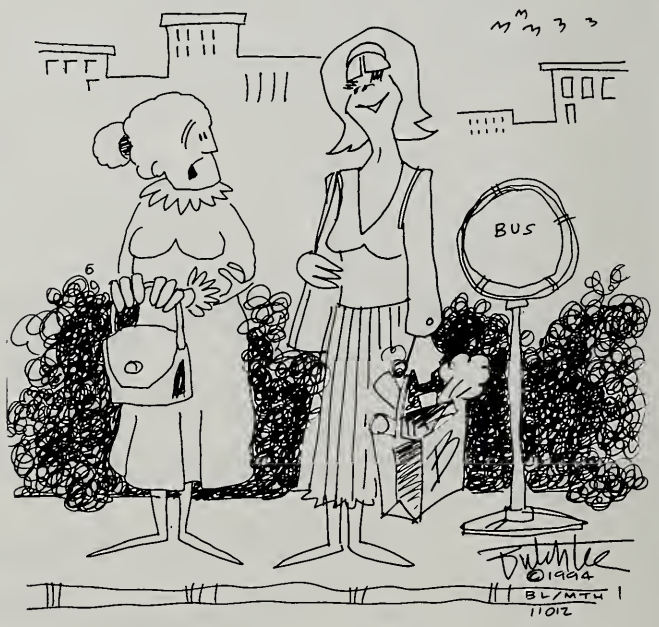
- ◆ Regional Outreach Program, Comfort Suites, August 14 - "Pediatric Critical Care," Manual Caceres, M.D.

Point Pleasant

- ◆ Pleasant Valley Hospital, August 22 - "Oral and Facial Lesions," Lee F. Allen, M.D., D.M.D., and David P. Wise, M.D., D.D.S.

Spencer

- ◆ Roane General Hospital, August 20 - "Treatment of Asthma," James P. Clark, M.D.



"I JUST SPENT AN HOUR AT THE DOCTOR'S. THAT WAS TEN MINUTES WITH THE DOCTOR AND FIFTY MINUTES FILLING OUT FORMS."

Sum-Sum-Summertime

Well, my friends, it's here at last,
That winter cold, a memory past,
As we enjoy the summer sun
And make plans for vacation fun.
There are, of course, still ill effects
For some the flood's up to their necks
As they attempt to make amends
For all the mess high water sends.
But most of us are high and dry
And, thankfully, look at the sky,
The days so long - - so much daylight,
With warmth each day, to our delight.
Out come the shorts and lightweight shirts
And even a few mini skirts.

Yes, summertime has just arrived
And pleasant thoughts are now revived.
We walk or run with head held high,
Or even on a beach do lie
To soak up all those U.V. rays.
Who cares what our physician says
About the damage to our to our skin
From too much of that melanin?
"I must get all the sun I can."
"I need to have a healthy tan!"
And summertime is much too short.
Before too long we'll hear report
Of colder temps and the first freeze,
Enough to turn the leaves on trees
Which then fall off to ground below
To wait for cover of the snow.

Ah, yes, how wonderful it is
That seasons change - - we dare not miss
The beauty of each one - - unique
For all to savour - - strong or weak.
These cycles of our earth and sun,
So many years ago begun.
I don't know what it says to you;
For me it makes it clear how true
It is: There's purpose in this life,
Despite the daily hurts and strife.
God made it to be otherwise.
It's time we opened up our eyes
And learned to live in harmony,
For that's the way we're made to be.
Take time this year and search within
For summer's more that tan on skin.
Spend time in thought and you will find,
Suprisingly, a peace of mind.

Bill Wallace, M.D.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

New report looks at firearm mortality in WV

Since 1970, deaths due to unintentional firearm injury have decreased in West Virginia and in the U.S. according to *"West Virginia and the United States: A Comparison of Firearm-Related Mortality Rates,"* a new study from the West Virginia Bureau for Public Health's Office of Epidemiology and Health Promotion (OEHP).

This report looked at trends in firearm deaths, and combines state data for the 10-year period between 1985 and 1994 to compare to national 1990 rates on the basis of age, gender, and race. It noted that rate of all firearm-related mortality in West Virginia from 1985 to 1994 was 16.0 deaths for every 100,000 residents, 8% higher than the comparable 1990 U.S. rate of 14.8 deaths per 100,000 residents. While the rate of unintentional firearm mortality was only slightly higher in the state than the nation, the rate among males was 40% higher.

Although unintentional firearm-related deaths have decreased, firearm-related suicides have increased in the state and the U.S., with rates of suicide due to firearms consistently higher in West Virginia than in the nation. Firearm-related homicide rates have fluctuated over time, with overall state rates being lower than the national rates.

The rate of firearm-related suicide among males was 38% higher in West Virginia than in the U.S., while the rate among females was 20% higher. White residents of the state had a rate of suicide due to firearms 23% higher than whites nationwide, while black residents of the state had a rate 67% higher than blacks nationwide.

The rate of firearm-related homicides was found to be 26% lower in West Virginia than in the U.S. However, among women only, the state rate was 15% higher than the national rate. White residents of the state had a rate of firearm-related homicide that was 19% higher than whites nationwide in 1990, while black West Virginians had a rate that was 30% lower than the national rate. However, data provided for the study from the state Division of Public Safety showed the rates of the firearm-related crimes of murders, felonious assaults and robberies to be much lower in West Virginia than in the nation as a whole.

The study also included surveys on firearm possession in West Virginia, but these surveys did not distinguish hunting firearms from other types of firearms. Estimates indicate that in 1995, nearly half (48%) of all adults in West Virginia had a loaded/unloaded firearm in their home, car, van or truck. About one in eight (12%) had a loaded firearm in their home, but only one in 20 (5%) stored their loaded firearms in a locked place. In addition, a survey of state youth in 1995 found that nearly 23% of male high school students and 2% of female high school students reported carrying a firearm during the previous month.

For a copy of the report or for more information, call (304) 558-9100.

Latest study on health risk factors released

A new report shows that more West Virginians than ever were buckling up in the first full year of state's mandatory seatbelt law. Before the law was passed in 1993, 40% of the state adults reported using seatbelts sometimes, seldom or never. But results of a 1994 survey show this rate was cut in half in the year after the passage of the law, with only one in five adults still not using seatbelts.

These and other findings about lifestyle behaviors that affect health are found in the *1994 Behavioral Risk Factor Survey*, a report just released by the West Virginia Bureau for Public Health's Office of Epidemiology and Health Promotion. In addition to nonuse of seatbelts, the other risk factors covered were high blood pressure, obesity, sedentary lifestyle, cigarette smoking, smokeless tobacco use, and alcohol misuse. Data were obtained by a random phone sample.

West Virginia continues to have high rates of several risk factors. Although it has been increasing nationwide as well, obesity is especially high in the state, with 35% of adults at least 20% above their ideal weight for height. Only Mississippi and Michigan ranked higher. In addition, the state ranked fourth in sedentary lifestyle (68%) and fifth in smoking (27%). The use of smokeless tobacco in West Virginia (8%) was second highest among the 24 states that included that topic in their surveys. Alcohol misuse, on the other hand, was again considered not to be a major problem. In 1994, only 3% reported having more than 60 drinks in the previous month, 10% reported having had at least five drinks on a single occasion, and 2% reported drinking and driving.

A special feature of this year's survery was the inclusion of county risk factor prevalences and rankings for the five-year period from 1990 through 1994. Counties with statistically significant differences from the state prevalences for the period are highlighted in the report.

In 1994, 49 states and the District of Columbia conducted Behavioral Risk Factor Surveys. This is the 11th year West Virginia has participated, and the findings are used to help establish health policies and to monitor disease prevention efforts.

For more information or for a copy of the report, call (304) 558-9100.

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Beauty marks can make you drop dead ~~gorgeous.~~

The fact is, beauty marks, moles, liver spots, even freckles, can develop into melanoma or another form of skin cancer. Left alone, melanoma will spread throughout your body and eventually kill you. Which is why you must examine yourself regularly. Look for changes in the shape or color of your beauty marks or moles. And watch for new marks that are larger than 1/4-inch, varied in color, irregular or asymmetrical in shape. If you find anything suspicious, see a dermatologist. Melanoma can be cured if caught early.

Spot Melanoma/Skin Cancer Early.

AMERICAN ACADEMY OF DERMATOLOGY
AAD
1938

Robert C. Byrd Health Sciences Center of West Virginia University News

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of WVU, Communications Division, Morgantown

WVU Hospitals opens surgery center

WVU's Ruby Memorial Hospital opened a new $3.1 million surgery center in June on the hospital's second floor which features $1.5 million in new medical equipment.

"The Ruby Day Surgery Center will help us provide better and faster service to patients who need surgical procedures," says Bernard Westfall, president of WVUH. "Advances in surgery have meant that many conditions which once required long stays in the hospital are now treated on an outpatient basis. The Ruby Day Surgery Center was designed to make these types of operations more convenient and comfortable for patients and their families."

The Ruby Day Surgery Center has 35,000 square feet and also includes WVU's Pain Management Center, where patients are treated for acute, chronic, and cancer pain. In addition, the Pain Management Center offers counseling, cancer outreach care, acupuncture and hypnotherapy.

To refer a patient to the pain center, call (304) 598-6200, Ext. 2577.

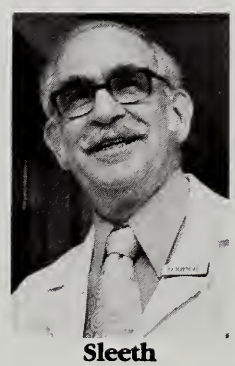
Dr. Prescott elected association president

Dr. John Prescott, chair of the WVU Department of Emergency Medicine, has been elected president of the Association of Academic Chairs of Emergency Medicine.

Dr. Prescott is also on the board of directors of the Society of Academic Emergency Medicine and chairs the Rural Emergency Medicine Task Force.

Procedures being performed at the Ruby Day Surgery Center include arthroscopic knee and shoulder reconstruction; biopsies; hernia repairs; mole removals, removal of polyps from stomach and colon; and sinus, laser, gallbladder and plastic surgeries.

WVU names Family Medicine Center in honor of Dr. Sleeth



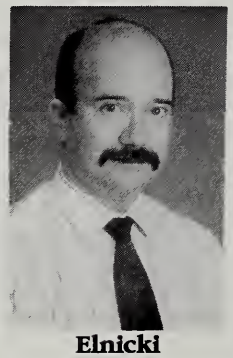
Sleeth

WVU has named its Family Medicine Center for the late Dr. Clark K. Sleeth, who died in 1982.

Dr. Sleeth, a 1938 graduate of the School of Medicine, served on WVU's medical faculty from 1941 to 1978 and was dean of WVU's School of Medicine for 10 years. A strong advocate of training primary care physicians, Dr. Sleeth helped to establish the Department of Family Medicine in the early 1970s.

The Family Medicine Center is located on the 4th floor of the HS Building and houses the offices of family medicine physicians on the WVU School of Medicine faculty, and examining rooms and treatment areas.

Dr. Elnicki receives national award



Elnicki

WVU internist Dr. Michael Elnicki has received the National Award for Innovation in Medical Education from the Society of General Internal Medicine for helping to develop, implement and disseminate a national curriculum on "telephone medicine."

WVU to test rhTPO

WVU is one of five U.S. bone marrow transplant centers chosen for one of the first human trials of a new growth factor, recombinant human thrombopoietin, that will be offered to bone marrow transplant patients to help them tolerate higher doses of chemotherapy.

We're helping you keep West Virginia healthy.

A doctor's job is more than healing patients when they're sick—doctors also work to keep their patients healthy. Carelink Health Plans helps doctors all over the state to provide the wellness programs West Virginians need to improve their health. Carelink salutes the West Virginia doctors who have made the Carelink connection to providing better health care to their patients.

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Marshall University School of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Med School providing support for athletes at Summer Olympics

Behind the scenes of the 1996 Summer Olympics in Atlanta, the MU's School of Medicine has been on call to help track and field athletes who become ill.

Marshall's expertise in sports medicine, international health and medical computing made it a logical resource, said Dr. Jim Kyle of Ripley, who was one of the 12 official facility physicians for track and field events at Olympic Stadium.

"At first glance, you might think our jobs as Olympic physicians would be limited to problems like injured knees or shoulders, but that's not the case at all," said Dr. Kyle, who serves on Marshall's volunteer physician faculty. "In reality, we're also going to be seeing diarrhea, rashes and other problems. With hundreds of athletes from all over the world - - and thousands more people in their delegations - - we could see any number of ordinary and exotic problems.

"We've got to be prepared for the what-ifs," he said. "If an athlete for the 100-yard dash comes in the day of the semifinals with a rash after being bitten by a mosquito, that's when the beepers will go off at Marshall."

Standing ready to answer calls have been Dr. Robert Walker, chairman of Marshall's family practice department; Dr. Rabah Boukhemis, a family physician and physical medicine specialist, and Michael McCarthy, who heads the school's Department of Academic Computing.

To undergird the project, McCarthy set up a World Wide Web page that gave Dr. Kyle targeted access to relevant Internet sources such as the *Emerging Infectious Diseases Journal*, *Malaria Weekly* and more.

"The technology that we developed to support medical students learning in rural communities was easily adapted to meet the special needs Dr. Kyle might have at the Olympics," McCarthy said. "Like our students, he had had electronic mail access to our faculty and other experts, as well as the ability to search Medline and other medical databases."

Marshall's medical students have been involved as well, learning to use Internet resources by addressing a problem Kyle posed from the Olympics site. Third-year medical student Janelle Thomas, an athletic trainer herself, worked with McCarthy to coordinate those activities.

Dr. Mark "Shark" Bird, who graduated from MU's medical school in May, accompanied Dr. Kyle to Atlanta to provide on-site technical support and medical informatics assistance.

MU ranked in top med schools in percentage of grads entering FP

Marshall again ranks among the top medical schools in the U.S. in the percentage of graduates entering family practice, according to figures from the American Academy of Family Physicians.

The school ranked sixth in the nation, with a three-year average of 27.9 percent of its graduates starting residencies in family practice. The academy honored Marshall by presenting the Silver Achievement Award, the university's fourth in as many years. The school received the Bronze Achievement Award in 1992, the first year of the program.

"This is a good sign that Marshall is fulfilling its mission, because family practice is overwhelmingly the specialty that serves people in smaller communities," said Dr. Robert B. Walker, chairman of Marshall's Department of Family and Community Health.

"We are proud and pleased that Marshall consistently is among the half dozen schools that receive such honors," he added.

Walker attributed the school's success to a generalist-oriented Admissions Committee and curriculum, strong role models in primary care, and a family-practice-friendly practice environment.

"West Virginians are extremely supportive of family practice," he said. "It is a specialty people respect, and students sense that."

Two science teachers learning basics of DNA research at MU

Carol O'Connell, a science teacher at Harts High School, and Bernard Adkins, a science teacher at Wayne High School, are learning the latest technologies in DNA research through Marshall's first DNA-related summer program for teachers.

Ms. O'Connell is participating through a Summer Teacher Research Fellowship from the American Society of Cell Biology (ASCB). She was one of only four high school teachers nationwide to receive a fellowship.

The ASCB is sponsoring this science education partnership to acquaint teachers with modern research tools and techniques, help them build a network with community scientists and institutions, and bring the excitement of research science into the classroom.

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An Invincible Team of 692

This is my last letter for the *Journal* so I am filled with nostalgia and joy. Since the year that seemed to just begin is almost complete, I believe it is important to examine the accomplishments of our organization.

One of my goals this year was to introduce a bill which would prohibit the sale of items rated for violent content to minors, just as we already have in place for sexually explicit items. The bill was introduced, but died a slow death in the Judiciary Committee chaired by Senator Wooten, who felt the bill had Constitutional conflicts. While this may be the case, Senators Blatnik, Bowman, Sharpe, Ross and Anderson signed onto the bill and I would like to take this opportunity to thank them publicly for their support.

Different ages are affected in unique and measurable ways by violent material. We must begin to recognize the symptoms of exposure to violence in order to protect our children from the hazards. Children who live with violence at their doors are more susceptible than any, yet when they go inside and turn on their TV or put on their headphones they are bombarded with more violence. Some of the symptoms correlated with the viewing of violent material are as follows: protective behavior with increased mistrust of others, desensitization to violence with apathy towards the perpetrator and the victim, and increased appetites for becoming involved in violence. I am very proud of calling attention to the need to protect our children from violent material. Of course, this was only one of the SAVE (Stop America's Violence Everywhere) projects the Alliance performed.

I would like to list some of the activities the Alliances throughout the state have performed for the health of West Virginia and the support of medical education:

- We provided Dr. Prithrow Stilth's Conflict Resolution Curriculums for Middle and High Schools with Alliances.
- Over 1,000 "Hands are Not for Hitting" placements were distributed to kindergarten and first graders.
- Self esteem classes were taught to over 4,000 students.
- Presentations concerning the negative effects of the violent content in the media were presented to PTA, church organizations and other parent groups.
- A total of $16,957 was raised for AMA-ERF to assist with the future of medicine by providing financial aid to medical students for education and medical schools for research.
- Computerized "Baby Think It Over" dolls were provided to high school students to show they the realities of what it's like to have a baby.
- Tobacco hazards were taught throughout the state, both with smokeless and smoking usages.
- Christmas shopping for needy children was made easier with an organized effort through community stores and the Alliance so merchandise was greatly discounted.
- A gubernatorial and numerous mayoral proclamations were awarded declaring "SAVE Day."
- Abuse shelters were assisted with financial grants as well as personal items and even food and furnishings.
- "I Can Choose Coloring Books" were distributed to over 6,000 primary students. This is a coloring book which lets children know they have choices over which they have control.
- Mini-internships were sponsored by two counties.
- CPR classes were offered.
- Healthy living with exercise and nutritional information was promoted by many counties.

Yes, the WVSMA Alliance has accomplished a tremendous amount of work with a very small budget and huge hearts. We are a TEAM who upholds our Mission Statement: Physician spouses dedicated to the Well-Being of Healthy West Virginians.

Thank you for allowing me to serve as president of this wonderful organization of superb people. Each time I consider their accomplishments I am humbled. I know that we will continue to assist West Virginia as Amy Ricard takes office in August. Together Everyone Accomplishes More - - We need to be unified for support in our projects and of each other as the atmosphere becomes increasingly caustic to medicine. We are an invincible TEAM of 675.

Linda Elliott
WVSMAA President

Christmas at The Greenbrier

Join the WVSMA Alliance for a Greenbrier Cooking Demonstration Lunchen/Fundraiser, Friday, August 23, 1996 at 12:30 p.m. (room to be announced)

The cost is $35 and includes the luncheon and cooking demonstration, valued at $30. Please make your reservation today by writing a check made payable to: WVSMA Alliance and mail to: Janie Altmeyer, 27 Elmwood Place, Wheeling, WV 26003. For more information, contact Janie at 1-800-501-8447.

SILENT ART AUCTION

The WVSMA Alliance will be having a Silent Art Auction during the WVSMA & Alliance Annual Meeting at The Greenbrier. If you have any art pieces you would like to contribute, please bring them to the Exhibit Hall before Friday morning, Aug. 23. A table will be there to display the artwork with cards attached for bidding. Make sure you spend some time viewing the pieces and making bids. For more information contact Janie Altmeyer at 1-800-501-8447.

The winners will be announced during the Jazz Festival Friday, Aug. 23 from 9:30 - 11 p.m.

All proceeds will go to AMA-ERF.

WESPAC Members

We would like to thank the following physicians and Alliance members for their 1996 contributions to WESPAC:
(This list includes contributors since the May/June *Journal.*)

Physicians

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**Designates more than $365*

Cabell
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Max Harned

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Sustainer Members - $100

Central
Anne Ramirez

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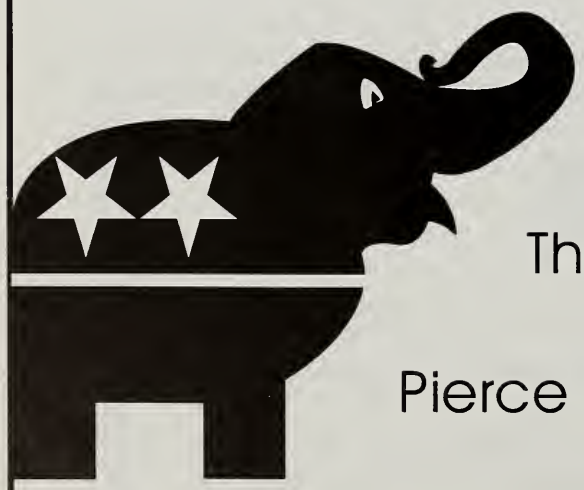
Ohio
Linda Elliott

Special Notice!

The WVSMA is inviting the gubernatorial candidates to speak at the WVSMA's Annual Meeting on Friday, August 23.

Please see the August issue of WESGRAM for more details!

WESPAC Annual Board Meeting



Thursday, August 22
4:30 p.m.
Pierce Room, The Greenbrier

WESPAC will be making candidate endorsements for the General Election.
Everyone is welcome to attend.

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Contributions are not limited to the suggested amount. Neither the AMA, the WVSMA nor the component medical societies will favor or disfavor anyone based on the amount of or failure to make PAC contributions. Contributions are subject to Federal Election Commission Regulations and the West Virginia Secretary of State Regulations.

Obituaries

Arthur Cecil Chandler, M.D.

Dr. A. C. Chandler, 93, who is described by his close friend Dr. G. A. Shawkey as "a gentleman, an outdoorsman, and a dedicated ophthalmologist," died May 18 in Hillcrest Convalescent Center in Durham, N.C.

Dr. Chandler was born on September 24, 1902, in Kittyton, Ind., one of eight children. His family later moved to Falls Mills, Va., and he attended nearby Bluefield College for two years and then earned his baccalaureate degree at The University of Richmond. In 1929, he graduated from the Medical College of Virginia, where he first met his wife, Laura, who was a patient undergoing an appendectomy.

After completing a rotating internship at Boston Children's Hospital, Dr. Chandler began practicing general medicine in Hinton in 1930. Laura, who was a Latin teacher, was teaching in Hinton and was rooming at the same boarding house where he was living. They were married the following year, and Dr. Chandler continued his practice in Hinton until they moved to New York so he could do postgraduate work at New York Eye and Ear Infirmary.

After his residency, Dr. Chandler opened his ophthalmology practice in Charleston in 1940. Except for the three years when he served in the Army Medical Corps in India and Burma during WWII, Dr. Chandler devoted himself to his practice until he retired in 1986.

Known to his many friends as "A.C.," Dr. Chandler was a pioneer in his specialty and the first board certified ophthalmologist in West Virginia. He performed the first corneal transplant in the state, and he founded the West Virginia Eye Bank. He prescribed the first contact lens in the state, which he made and fitted himself. He was a leader in the use of lens implants for cataract patients, and he quickly established his reputation as an expert in muscle surgery for strabismus.

During his career, Dr. Chandler served as president of the Kanawha Medical Society and of the West Virginia Academy of Ophthalmology, which he helped to found. He also founded the Kanawha Ophthalmologic Society and was a member of the AMA, WVSMA and the American Academy of Ophthalmology. Dr. Chandler also served as a board member and chairman of the board of Bluefield College, and took time from his practice for a few summers to serve on the hospital ship HOPE in South America.

An avid outdoorsman, Dr. Chandler loved fishing and hunting. He had a close-knit group of friends who went on regular outings, especially bird hunting, and he belonged to the Flemming Hunt Club in Virginia. He took up flying in the late 1960s and achieved the Instrument Rating, and also enjoyed playing golf and bowling. In the final months of his life, he and a great-nephew bought a boat and made frequent fishing trips.

Mrs. Chandler became very frail in her later years, and Dr. Chandler caring for her at their Charleston home until her death in 1992. The next year, Dr. Chandler moved to a retirement village in Chapel Hill, N.C., so he could be near one of his sons, Dr. A. C. Chandler Jr., who is an ophthalmogist at the UNC. His other son, John Davis Chandler, is involved with TV and movie production in California.

Dr. Chandler had experienced a short illness for which he was hospitalized, and then he was transferred to the convalescent center where he died. In addition to his sons, Dr. Chandler is survived by four grandchildren and two great-grandchildren, and he is deeply missed by all who knew him.

Special thanks to Drs. G. A. Shawkey, J. P. Aliff, P. F. Francke, James T. Spencer Jr., and A. C. Chandler Jr., for their contributions and assistance with this obituary.

Frank S. French, M.D.

Frank S. French, M.D., of Glen Dale, died March 21 in Reynolds Memorial Hospital in Glen Dale.

Dr. French was born in 1902 in Rochester, N.Y., and received both his undergraduate and medical degrees from Cornell University. After receiving his M.D. in 1931, Dr. French interned at Clifton Springs Sanitarium Clinic in Clifton Springs, N.Y., and then completed a specialty internship in medicine at St. Vincent's Hospital in New York. Following his work at St. Vincent's, Dr. French did a one-year preceptorship at the NYU College of Medicine.

An Army veteran, Dr. French served with the 19th General Hospital in the European Theatre. After his service, he joined the U.S. Public Health Service, setting up residence training programs in the Hospital Division. He was the chief of medicine at the Public Health Service Clinic in Mobile, Ala., and the U.S. Marine Hospitals in both Detroit and San Francisco.

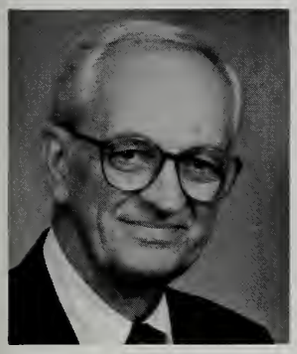
Dr. French then served as medical director of the U.S. Public Health Service Hospital in Long Island and the U.S. Public Health Clinic in Philadelphia. During this time he served as associate chief of the Branch of Health, Bureau of Indian Affairs, in Washington, D.C.

In 1966, Dr. French retired from the U.S.P.H.S. and moved to West Virginia in 1968 to become the assistant state health director. From the early 1970s until he retired in 1976, Dr. French worked part time with family practitioner Dr. Kenneth Allen in Glen Dale.

Dr. French was a contributor to the John Knickerbacker Scholars of Cornell University. He was a member of St. Francis Xavier Catholic Church, Moundsville; and a member of the Moundsville VFW Post No. 437.

In addition to his parents, Dr. French was preceded in death by his wife, Mary E. Fellers French on December 26, 1983; and his foster parents, Mr. and Mrs. Wilcox. Memorial contributions may be made to the St. Francis Xavier Catholic Church, Moundsville.

John McMaster Hartman, M.D.



John McMaster Hartman, 68, a respected Charleston internal medicine specialist who had served as an associate editor of the WVSMA's Publication Committee since 1972, died of cancer at his home on June 26.

A native of Charleston, Dr. Hartman received his A.B. degree from West Virginia University in 1949 and his M.D. from the University of Maryland in 1953. After serving in the U.S. Navy from 1953-56 and interning at the U.S. Naval Hospital in San Diego, Dr. Hartman completed a residency at Ohio State University Hospital and did a fellowship in cardiovascular research.

In 1960, Dr. Hartman opened his practice in Charleston and throughout his career he was known for his outstanding diagnostic abilities and compassionate bedside manner. Dr. Hartman had been diagnosed with cancer a year before his death, but he continued to care for patients until shortly before his death.

During his career, Dr. Hartman performed Charleston's first heart catherization and wrote many scientific articles and editorials for the *West Virginia Medical Journal,* which he has been an associate editor of since 1972. One paper Dr. Hartman co-authored was the first to demonstrate the association between certain physical and neurological disorders and Friedrich's Ataxia.

An associate professor of medicine at the Robert C. Byrd Health Sciences Center of WVU, Charleston Division, Dr. Hartman was an active staff member of CAMC's Department of Medicine. He was a past president of the West Virginia Society of Internal Medicine and belonged to Alpha Episilon Delta Fraternity. A member of the Charleston Rotary Club and Christ Church United Methodist, Dr. Hartman also served on the board of the United Fund.

Dr. Hartman is survived by his wife, Elisabeth; daughters, Elisabeth Cannell of New York, and Mary Hartman of Savannah, Ga.; sons, John Jr. of Danbury, N.C., and Willliam M. of Quincy, Mass.; brothers, Robert L. Jr. and James R., both of Charleston; and one grandchild. The family suggests donations be made to the CAMC Foundation or Christ Church United Methodist.

Please see page 179 for a Special Editorial about Dr. Hartman.

Claire Marie Cook-Reiter

Claire Marie Cook-Reiter, executive director of the Ohio County Medical Society who was fondly known as "Ree" to her many friends, passed away at her home on April 19 after a long bout with ovarian carcinoma.

Ree entered the medical scene at age 25 after working at Oglebay Institute where she participated in helping produce entertainment of all kinds including arts and crafts. Her costuming of stage events earned her a national prize of which she was justifiably proud. Her first position at the Ohio Valley Medical Center was that of secretary, but she rose to become the director of Quality Assurance. Some of the standards she set were copied extensively, and her work in this field and also with the teaching program earned her the deep respect of the medical community.

Following the diagnosis of malignancy, she underwent surgery and chemotherapy, and then resigned from Ohio Valley Medical Center and accepted a part-time position as executive director of the Ohio County Medical Society. This permitted her the opportunity to participate in other regional functions and she served as president of the Ohio Valley Medical Center Auxiliary, and as a board member of the United Way of the Upper Ohio Valley, the Wheeling Symphony and the Wheeling Victorian Society. She also served on the Advisory Committee of the local YWCA, and as a member of the Wheeling Country Club she enjoyed membership of the Women's Golf Association.

Ree was in demand for staging fashion shows and other entertainments using her experience and training as a model. When she was president of the Ohio Valley Medical Center Auxiliary, Ree helped establish the OVMC Women's Center, which is currently being renamed The Ree Cook-Reiter Women's Center. In addition, the Ohio Valley Medical Society is honoring her by recognizing her fascination with golf and naming their annual golf prize the Ree Cook-Reiter Golf Cup.

Ree has been named the recipient of this year's WVSMA Presidential Citation, which will be presented on Friday, August 23 at The Greenbrier during the WVSMA's Annual Meeting. She is sadly missed by her husband, Dr. Martin Reiter, her relatives and her many friends.

West Virginia Medical Journal

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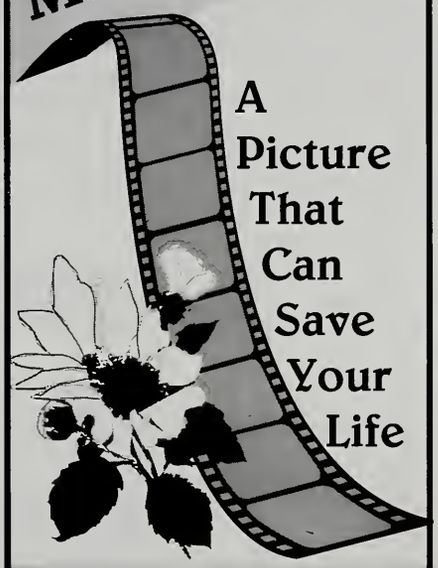

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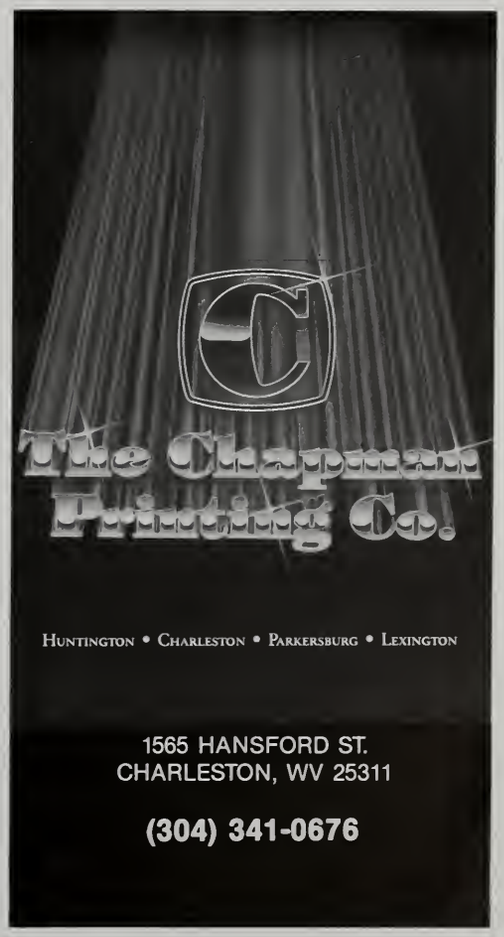

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West Virginia Medical JOURNAL

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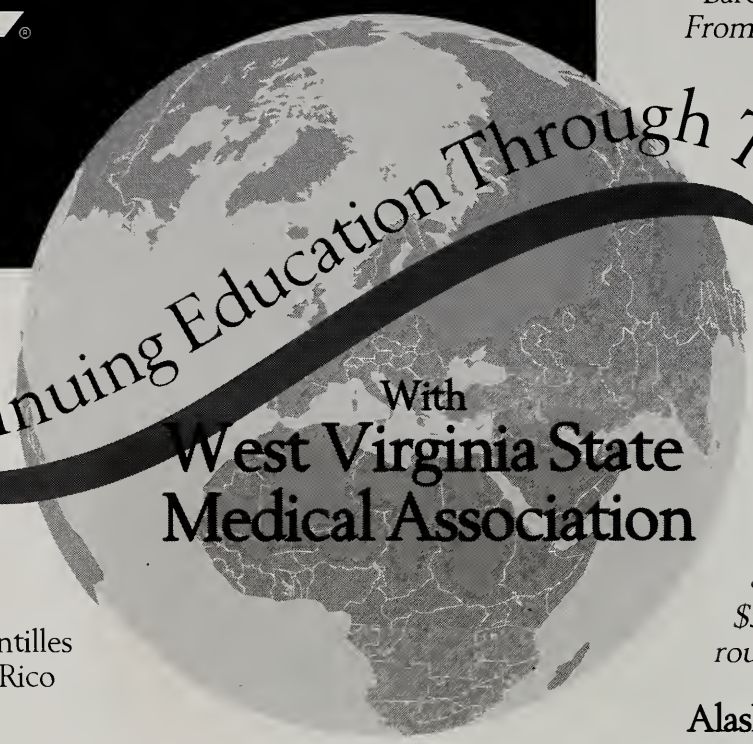

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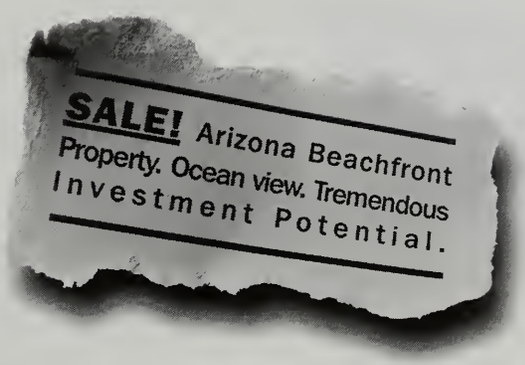

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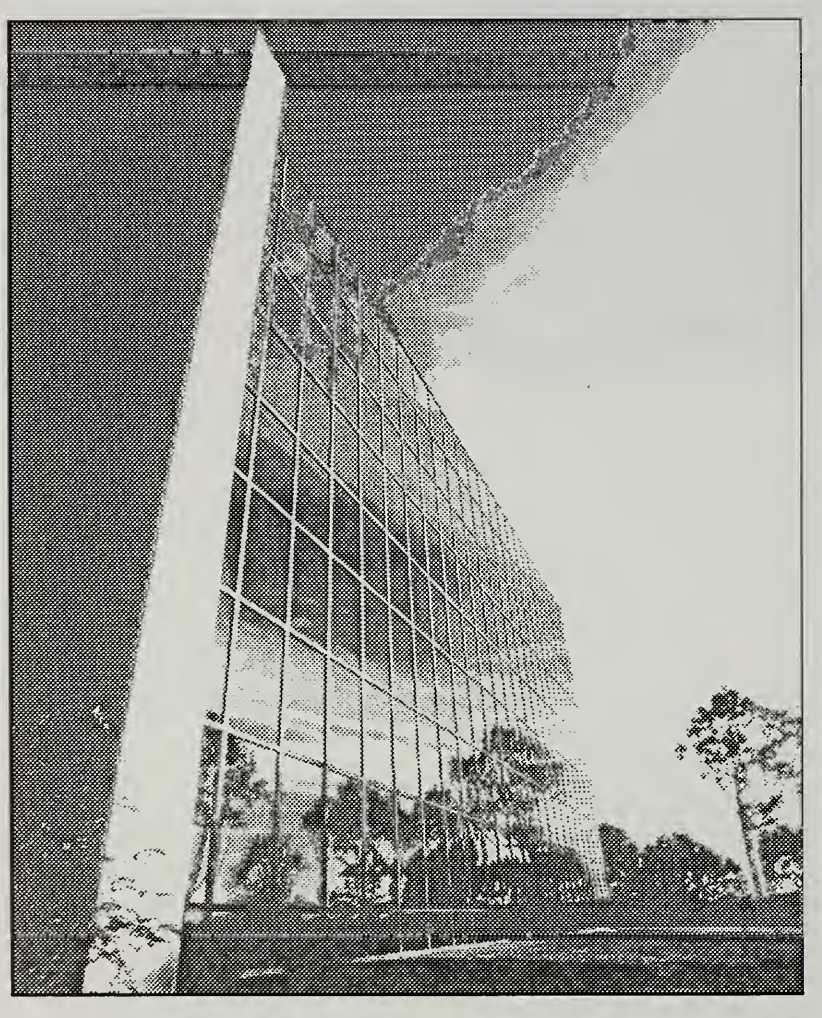

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Charleston, WV 25364
1-800-257-4747 or (304) 925-0342

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The **West Virginia Medical Journal** is published bimonthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue SE, Charleston, WV 25304, under the direction of the Publication Committee. Original articles are accepted on the condition that they are contributed solely to the *West Virginia Medical Journal.*

The views expressed in the *West Virginia Medical Journal* are those of the individual authors and do not necessarily reflect the policies or opinions of the *West Virginia Medical Journal*'s editor, associate editors or its staff, or the West Virginia State Medical Association's staff. Publication of an advertisement is not to be deemed an endorsement of any product or service unless otherwise stated.

Subscription Rates:
$45 a year in the United States
$80 a year in foreign countries
$4 per single copy

POSTMASTER: Send address changes to the *West Virginia Medical Journal,* P.O. Box 4106, Charleston, WV 25364.

Entered as second-class matter, January 1, 1926, at the post office at Charleston, WV, under the act of March 3, 1879.

USPS 676 740
ISSN 0043 - 3284

Claims for back issues must be made within the six-month period after publication. Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

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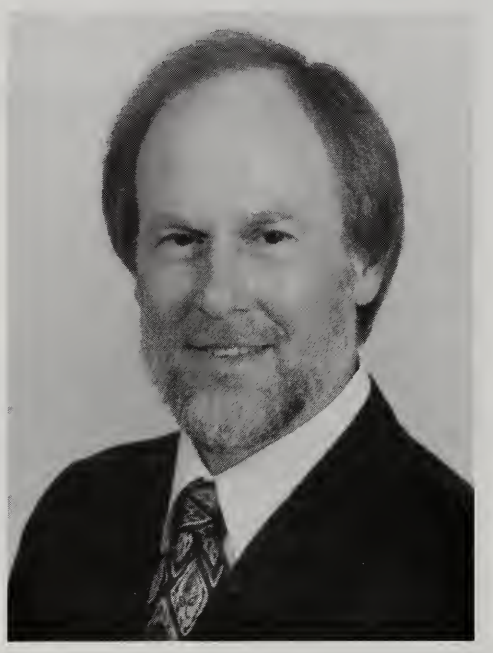
The Mountaineer Balloon Festival in Morgantown.

Photo by David Fattaleh
West Virginia Department of Commerce.

WE . . . ARE . . . PHYSICIANS

Editor's Note: *The following is Dr. Cordell's inaugural address which he delivered on Saturday, August 24 during the WVSMA's Annual Meeting. Photographs and other highlights from this year's Annual Meeting are published in this issue beginning on page 242.*



We are physicians. Now, that may seem obvious. However, that concept is under fire from many directions.

We are referred to as "care managers," "gatekeepers," or the now ubiquitous and ambiguous term - - "providers." Our patients suffer the same fate; they are referred to as "clients," "customers," "subscribers," or "covered lives." While we used to deliver medical care to our patients, we now have a "product" and patient visits are "encounters.

The sterile vocabulary of the business world now attempts to define the richness and wonder of providing medical care to our patients. Evidently, those who are solely in the business of medicine feel that the only way to control medicine is to dehumanize it and make it fit into a box or a mold. If they can convince us that one size does indeed fit all, then we will willingly follow the lead of the managed care organizations; we will accept the pronouncement from a disembodied voice over the phone saying that we may or may not admit our patient to the hospital.

How do we reclaim the practice of medicine for our patients? As stated by Dr. Jane Orient, executive director of the Association of American Physicians and Surgeons, "We are fighting to preserve the essential tenets of medicine - - "first, do no harm" . . . "do what is best for the patient" . . . "involve the patient in making the best choices for his or her care no matter what the prevailing fad is concerning the organization of care or the payment for care."

Cardinal Bernardin put it very succinctly in his December address to the AMA: "We must regain the moral center of medicine and renew the covenant with patients and society. That covenant is grounded in the moral obligations that arise from the nature of the doctor-patient relationship - - placing the good of the patient over the interests - - financial or otherwise - - of the physician, insurance company, hospital or system or care."

We, as physicians, are the guardians of these tenets. We must begin the work of preserving them.. That means that we must all become active as patient advocates at every level. We must take the time to explain the changes to our patients and let them know how their lives will be affected.

Will they still be able to see the physician of their choice?

Will they still be able to see the specialists who have managed more complex medical problems for them?

What steps will they be required to take before they can see their doctor?

The answers are not all good or all bad, but our patients must be educated that the changes are occurring and that we, as their physicians, are concerned that they continue to have access to appropriate care. And, make no mistake, we, the physicians, are still the only ones who are trained to provide that care for our patients. The success or failure of any system of health care is ultimately dependent upon the physicians who provide the care.

We must all become active in the political arena. While not all of us can run for political office, we must support physicians who do. Likewise, we must support non-physician candidates who are interested in working with the medical community to make appropriate and well-considered changes to the laws and statutes governing health care.

Give of your time - - talk with your office staff and patients. Give contributions to the candidates of your choice. If you feel comfortable doing so, place candidate brochures in your office waiting room. Host fund-raisers. Talk with candidates and legislators and make your views known on the issues. You can be sure that those who are on the opposing side will not hesitate to make their views known. We must speak up to fight the continued intrusion of government and other third parties into the interaction between patients and physicians.

We have many issues of concern to medicine - - rationing of care, accessibility of care, portability of

insurance, patient control via medical savings accounts of their health care expenditures, payment denial by health plans after care has been provided, physician non-selection or de-selection by health care plans without due process, and lack of tort reform. We again are facing a litigation explosion, but we have yet to see such common-sense changes in our tort system as revision of the joint and several liability statutes, disclosure of collateral sources of payment such as insurance or other civil actions, periodic structuring of payments, caps on legal fees, or pre-filing certification that a case has merit. We have no protection for any of our citizens of this state from seizure of their home and contents to settle an award.

We must all speak out if we are to effect change in any of these areas. If we remain silent, the practice of medicine as a profession is surely threatened. We must rise to the challenge to protect and nurture the unique qualities that define the patient-physician covenant.

Get involved in your hospital and in any of the managed care organizations with which you may choose to participate. Only by having physicians involved in the decision-making processes of these organizations can the rights of our patients to compassionate, ethical care be protected. We must stand up for the confidentiality of our patients' medical records. We must speak out to make sure that health care dollars are indeed directed to providing health care, not to empire building by the large corporations.

Finally, we must maintain the other relationship in medicine - - the physician-physician relationship. In spite of all the forces seeking to divide and conquer, pitting physician against physician, and specialty against specialty, we must respect and support each other as physicians and colleagues, respecting each other's unique skills and training instead of rushing headlong into mindless competition with one another. We must not sacrifice our professionalism to the false gods of market share or captive patient population. We must continue to do what is right and good.

Let us find within the profession of medicine, from all the years of our training, the strength to persevere - - to realize that we are physicians - - not merely providers. The only way to achieve our goals is for all of us to pull together, to become active participants in defending the sacred relationship between us, as physicians and our patients.

Ronald E. Cordell, M.D.

Dr. Ronald E. Cordell, the WVSMA's new president, and his wife, Joann, son, Chad, and daughter, Andrea.

Macropolitics

West Virginia physicians should have no problem with indecision in the voting booth this year. A candidate for governor of West Virginia who has as one of her major supporters plaintiff attorneys and a scoundrel in the White House seeking reelection should encourage phyicians to get to the polls early.

It should also strongly encourage them to talk to their patients and explain to them just why a vote for either of these two undesirables is not in the interest of anyone who values good medical care. Besides the medical issue there might be a few other issues involving character, trustworthiness and special interest accomodation which might come to mind in any conversation concerning the merits, or lack of them, of the two.

Dark clouds seem to hover over the possibility of defeating either at the present time. There are simply not enough Republicans in West Virginia to defeat any Democrat running for statewide office without significant erosion of their Democratic support. There are some hopeful signs to indicate that such an erosion is occurring in our governor's race. This phenomenon needs to be encouraged in any way possible.

Nationally, our president seems to generate the same degree of fervor and adulation afforded any movie or rock star. He, appropriately enough, responds with a moral outlook and lifestyle befitting such an image. As a nation, we deserve something better than that. Polls indicate that at present this opposition is running about 20 percentage points behind.

Will a vicarious shame felt for him overcome the undiscerning support given by crowds of enthusiasts tittilated by his infidelities, his indiscretions and his larcenous approach to public life? We believe this is possible. Many of us may have rooted for the fleeing outlaws in *Butch Cassidy and the Sundance Kid*, but later, upon sober reflection probably concluded they got what they deserved.

No matter the short-term outlook, in the long-term things seems to be brightening. It has been observed by others that a pronounced conservative tide has been developing in the United States in recent years. The 1994 congressional elections were a strong indicator of this change in philosophy. The rejection of the health care takeover attempted by the Clintons was an earlier indication.

The right wing nut organization of paramilitary militias was an early harbinger of serious, if squirrelly, unhappiness and dissatisfaction with the intrusiveness of government. This unhappiness and dissatisfaction is certainly not confined to our lunatic fringe; the insurrection and violence proposed as a corrective measure is. The ballot box provides an acceptable and appropriate response to the unhappiness and dissatisfaction of a vast majority of our citizens. Attempts at organizing third parties and the establishment of voting blocs such as the Christian Coalition are evidence of this.

Whatever outcome this year's elections may present, West Virginia physicians will play the game accordingly. As knowledgeable citizens, West Virginia physicians have a responsibility to influence that outcome by all legitimate means.

Stephen D. Ward, M.D.
Editor

Letters To The Editor

Acute renal failure after administration of Losartan

We feel it is important to alert readers about a case report of acute renal insufficiency secondary to administration of losartan, a new angiotensin II receptor inhibitor. This adverse effect has been reported only once in medical literature.

A 30-year-old status post cadaveric renal transplant in March 1995 began receiving losartan/hydrochlorthiazide 50/12.5 mg/day (Hyzaar®, Merck & Co., Inc.) for hypertension. The patient's serum creatinine level at that time was 1.4 mg/dL. Medications at that time included cyclosporine (Sandimmune®), digoxin, levothyroxine, extended-release nifedipine, prednisone and ranitidine.

Approximately one week later the patient presented to an outlying hospital with complaints of decreased urine output and numbness of the legs and extremities. Lab evaluation at that time showed a sodium of 126 mmol/L, potassium 6.0 mmol/L, chloride 99 mmol/L, blood urea nitrogen (BUN) 30 mg/dL and creatinine 2.3 mg/dL. Urinalysis was negative for protein. Urine output was < 1000 ml/24 hours and an EKG showed a QRS interval of 2.5 mm with elevated T waves. The patient was then transferred to our institution for further evaluation.

Upon arrival to our facility, laboratory values showed a BUN of 32 mg/dL and creatinine 2.2 mg/dL. Cyclosporine level (TDX method) was therapeutic at 378 ng/ml. The patient was started on intravenous fluids and the losartan/hydrochlorthiazide was discontinued. Renal function returned to baseline 48 hours after admission (BUN 22 mg/dL, creatinine 1.5 mg/dL, potassium 4.3 mmol/L) with recovery of urine output (> 3,000 ml/24 hours).

Losartan inhibits the binding of angiotensin II to its receptor sites and thus causes pharmacological blockade of the renin-angiotensin system (1). Inhibition of angiotensin II can cause a significant decline in renal function especially in patients with risk factors such as the increasing age, pre-existing renal insufficiency, renal artery stenosis and use of diuretics (2).

Our patient was at risk of renal dysfunction because of his recent renal transplant. Angiotensin converting enzyme inhibitors (ACE-I) have been documented to cause deterioration of renal function, resulting in increases in serum creatinine and potassium (3,4). Losartan, because of its similar pharmacologic effect, would be expected to have a comparable effect on renal function. A search of the MEDLINE database for reports from 1985 to 1996 showed one case report of renal impairment associated with losartan which resolved after discontinuation of losartan (5).

We suggest that when prescribing losartan for patients at risk for renal insufficiency, clinicians should consider the possibility of renal dysfunction as with ACE-inhibitors and monitor renal function periodically during therapy.

R. Vaughn Lamb, M.D.
Clinical Associate Professor of Internal Medicine
WVU School of Medicine, Charleston Division

Ted Walton, Pharm.D., BCPS
Charleston Area Medical Center
Pharmacy & Drug Information
Charleston, WV

(Please contact authors for references.)

Warning: Radial Keratotomy (RK) and Photo Refractive Keratotomy (PRK) incompatible with military service

A history of kerato-refractive surgery or corneal laser surgery is disqualifying for appointment, enlistment, or induction for all applicants to the Armed Forces. As stated in the Department of Defense's Directive 6130.0, physical standards for appointment, enlistment, and induction, which is dated May 2, 1994, any person who has undergone RK/PRK is disqualified from accession to the Armed Forces.

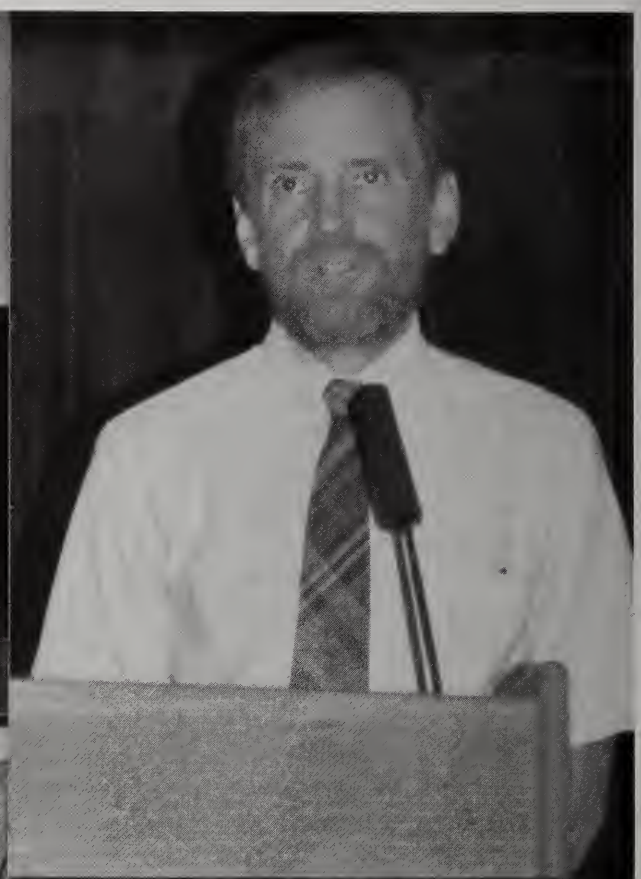
In other words, any person who has undergone RK/PRK cannot join the Armed Forces (including the Reserve components) and if in the military (including Reserve Forces) such operations will be disqualifying for continued duty. Medical concerns regarding RK and PRK include eyesight which is not correctable, even with lenses, increased effects of glare, night vision difficulties and long-term results.

Therefore, it is recommended that physicians who operate on patients with such procedures include this information in their informed consent.

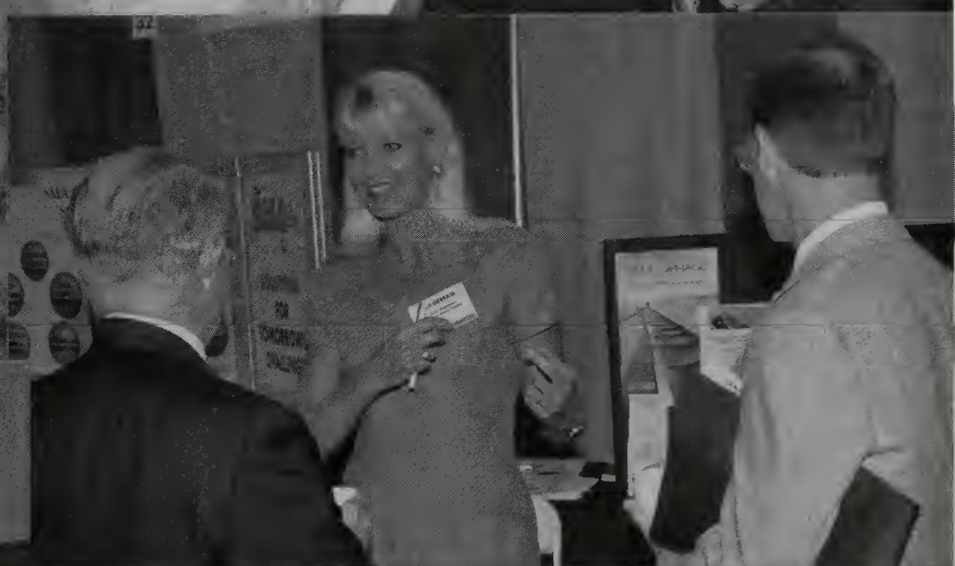
Ralph S. Smith Jr., M.D.
Colonel, Medical Corps,
State Air Surgeon
West Virginia Air National Guard

Annual Meeting Highlights

Photographs



(Top left) **Dr. Mildred Mitchell-Bateman, the former director/commissioner for the WV Department of Mental Health who is now a professor of psychiatry at Marshall University, was honored to receive the Wyeth-Ayerst Physician Award for Community Service. Dr. James Helsley, WVSMA's president for 1995-96, presented the award.** ***(Top right)*** **Dr. Daniel Doyle, a family practitioner in Scarbro, delivers his acceptance speech after being named Rural Physician of the Year.** ***(Bottom left)*** **WVSMA Alliance member Sherry Holloway proudly hands AMA-ERF checks to Gay Jackson of the MU School of Medicine and Dr. William Neal of the WVU School of Medicine.** ***(Bottom right)*** **Dr. Martin Reiter and his daughter, Deborah Krupa, proudly pose with the plaque he accepted in honor of his late wife, Ree Cook-Reiter of Wheeling, who was awarded this year's Presidential Citation for her many contributions to the medical profession.**



(Top left) **Always a stunning couple, Dr. C. Vincent Townsend and his wife, Sara, look spectacular as they visit the PIE reception for gubernatorial candidate Cecil Underwood.** ***(Top right)*** **Libertarian gubernatorial candidate Dr. Wallace Johnson and Republican gubernatorial candidate Cecil Underwood were interviewed by Beckley Register/Herald reporter Mannix Porterfield after their speeches at the meeting.** ***(Center)*** **Jerri Kaufman of Bristol Myers Squibb greets physicians at her company's booth in the Exhibit Hall.** ***(Bottom left)*** **Friends since med school, Dr. Sherman Hatfield, treasurer for the WVSMA, and AMA Alternate Delegate Dr. Robert Hess enjoy catching up with each other.** ***(Bottom right)*** **The members of the WESPAC Board met to discuss candidates for the General Election and WESPAC contributions.**

(Top left) Dr. Ron Stollings poses a perplexing question during the Lunch & Learn on *"The Terminally-Ill Patient: Is Physician-Assisted Death the Answer?" (Top right)* Dr. Alvin Moss, the keynote speaker for Thursday's Lunch & Learn, listens as Dr. Alex Azar, president of the Medical & Chirurgical Faculty of the State of Maryland, describes his feelings about physician-assisted suicide. *(Center left)* Dr. Gordon Murray of WVU, presented this year's Thomas L. Flink Address on the topic of *"Graduate Surgical Education - At Risk." (Center right)* Dr. Joseph Talley delivered a fascinating address entitled *"Treatment with Controlled Substances - - How to Keep Your License"* for Friday's Lunch & Learn. *(Bottom left)* Dr. Stafford Warren of Charleston gave an outstanding lecture on *"Non-surgical Treatment of Heart Disease." (Bottom right)* Dr. Stephen Ward *(third from left)*, editor of the *West Virginia Medical Journal,* met with three of the associate editors Drs. Joe Jarrett, Robert Marshall and Harvey Reisenweber at the Annual Meeting.

(Top left) **The reception sponsored by Medical Assurance of WV and Acordia of WV was a popular social event at this year's meeting.** ***(Top right)*** **Steve Brown of Medical Assurance of WV chats with Dr. Rigoberto Ramirez of Buckhannon.** ***(Center left)*** **AMA President Dr. Daniel Johnson enjoyed talking with WVSMA leader Dr. James Helsley, his wife, Vickie, son, Benjamin, and Chuck Ellzey of Medical Assurance and his wife, Bev.** ***(Center right)*** **Tamara Lively and Rob Vass of Acordia were pleased to help host the reception.** ***(Bottom left)*** **Dr. Derrill Crowe, president of Medical Assurance of WV, the WVSMA's endorsed malpractice carrier, provided members with an update about the company's activities. Dr. Harry Shannon, who was elected vice speaker of the House of Delegates, visited with Dr. Jerome Melchior, president of the Indiana State Medical Association, his wife, Martha, Dr. Sandra Olsen, president of the Illinois State Medical Society, and Dr. Jonathon Rhoades Jr., president of the Pennsylvania Medical Society.**

In the swing on the course during the golf tournament were *(top from left to right)* Dr. Jeff Stead, who chaired the tournament; Dr. Harry Shannon of Parkersburg; and Council Chairman Dr. Dennis Burton. Participants in the tennis tournament included Sharon Griffith of Oasis Pain Management *(right)* whose company sponsored the trophies for this event; and WVSMA Alliance member Carole Scaring *(left)*.

Winners of golf trophies included Dr. Sandra Olsen, president of the Illinois State Medical Society *(top left),* who is pictured with Michelle Ellison, public relations manager for the WVSMA; and Dr. Tom Pearcy of Charleston *(bottom left)*. The happy recipients of some of the many door prizes that were presented included Dr. Kenneth Allen of Glen Dale *(top right)*, and Dr. Michael Fortunato of Wheeling.

(Top left) **New Alliance President Amy Ricard is congratulated by her husband, Dr. Jose Ricard, after her inauguration.** ***(Top right)*** **Alliance member Alice Jo Hess presents Ruth Gilbert with her award for being named Alliance Member of the Year.** ***(Center)*** **The new Alliance officers prepare to take their oath of office.** ***(Center right)*** **Alliance leaders Kathy Fortunato and Janie Altmeyer ham it up in their Village People outfits which they wore for a skit to promote membership. (Bottom left) The luncheon featuring a cooking demonstration by a chef from The Greenbrier was an very successful event at this year's WVSMAA Annual Meeting.**

(Top left) AMA President Dr. Daniel Johnson gestures to make a point during his speech before the House of Delegates. *(Top right)* After his inaugural address, new WVSMA President Dr. Ronald Cordell relaxes at the reception with Dr. David Sparks, one of his partners at Associated Radiologists, Inc., and Bill Ferrell, executive director of Kanawha Medical Society. *(Center left)* Dr. Thomas Chang, the WVSMA new vice president, and Dr. Cordell, greet guests at the reception on Saturday afternoon. *(Center right)* As one of his first new duties, Dr. Cordell presents Dr. Janelle Duremdes with the grand prize at this year's meeting - - a weekend at The Greenbrier. *(Bottom left)* Dr. Elizabeth Spangler conducts a meeting of the Annual Meeting Program Committee for 1997.

Resolution 1 (Not Adopted - Currently Covered by WVSMA Policy 15.000-003)

WHEREAS, vision testing is done only at the initial application for a West Virginia drivers license;

WHEREAS, a person can now legally drive a motor vehicle for 60 years or more without verification that they can see well enough to steer their automobile safely (3,000-4,000 lbs. of steel) at speeds legally up to 65 miles per hour; therefore be it

RESOLVED, that the WVSMA shall seek the enactment of a mandatory law to require persons to have a vision check at the time of their drivers license renewal in the same manner using the same criteria or better methods as are currently used to grant initial drivers license during the next session of the West Virginia Legislature to improve the safety and protect the property of West Virginians.

Resolution 2 (Substitute Resolution Adopted)

WHEREAS, as the State and Federal levels of Government have proposed some type of Tort Reform, and

WHEREAS, citizens of West Virginia have no protection from seizure of homes, pensions and IRA (Individual Retirement Accounts) from litigation, and

WHEREAS, the State of West Virginia has not enacted any Tort Reform in past years; therefore be it

RESOLVED, that the WVSMA amend existing Policy No. 435.000-005 by deleting the period and adding the following language: "and, seek enactment of legislation for protection of Individual Retirement Accounts (IRA) and all other federal and state approved retirement plans from professional liability judgment creditors."

Resolution 3 (Substitute Resolution Adopted)

WHEREAS, more than 20% of the cost of medical care is in administrative costs, and

WHEREAS, insurance companies and third party payors have different standards for Utilization Management, Quality Assurance and claim forms, and

WHEREAS, this does not contribute to the quality of patient care; therefore be it

RESOLVED, that the WVSMA support a unified reporting system of Utilization Management, Quality Assurance, and credentialing.

Resolution 4 (Not Adopted - Currently Covered by WVSMA Policy 505.000-002)

WHEREAS, West Virginia has a very high rate of tobacco use, and

WHEREAS, passive smoke inhalation has been shown to cause health problems, and

WHEREAS, the State of West Virginia has shown tobacco to be a major cause of health problems; therefore be it

RESOLVED, that the WVSMA support an increase in the tax on all forms of tobacco to reduce the cost of medical care.

Resolution 5 (Not Adopted)

WHEREAS, medical treatment should be comprehensive and determined by medical science, and

WHEREAS, medical care is delegated to licensed professionals; therefore be it

RESOLVED, that the WVSMA be opposed to legislated "piecemeal" solutions for medical problems.

Resolution 6 (Not Adopted)

WHEREAS, the State of West Virginia has finally passed a seat belt law and

WHEREAS, the current law needs to be strengthened in regards to mandatory enforcement and stiffer penalties, and

WHEREAS, a strictly reinforced seat belt law has shown to reduce injuries and save lives; therefore be it

RESOLVED, that the WVSMA support a stricter seat belt law.

Resolution 7 (Not Adopted)

WHEREAS, the State of West Virginia has finally passed a seat belt law, and

WHEREAS, the current law does not require mandatory seat belt use on school buses, and

WHEREAS, the children of this State are one of our most important assets; therefore be it

RESOLVED, that the WVSMA support a stronger seat belt law that requires mandatory seat belts on school buses.

Resolution 8 (Not Adopted - Currently Covered by WVSMA Policy 165.000-001 (g)

WHEREAS, Medical Savings Accounts (MSAs) allow patients to purchase catastrophic insurance and accumulate funds for medical costs below $2,000-$3,000 per year and foster individual responsibility and frugality for medical care; therefore be it

RESOLVED, that the WVSMA support Medical Savings Accounts (MSAs) and urge our State Representatives to Congress to draft or support national legislation for tax-free MSAs.

Resolution 9 (Substitute Resolution Adopted)

WHEREAS, health reform is occurring in an unbridled competition for the cheapest care, and

WHEREAS, physicians and patients should be free to discuss insurance plan restrictions and medical care options without the physicians worrying about retaliation from insurers; therefore be it

RESOLVED, that the WVSMA seek the enactment of a Patient Protection Act (PPA).

Resolution 9 (Addressed in 1997 Legislative Agenda)

Resolution 10 (Addressed in 1997 Legislative Agenda)

Resolution 10 (Not Adopted)

WHEREAS, health care reform is occurring in an unbridled competition for the cheapest care, and

WHEREAS, physicians and patients should be free to discuss insurance plan restrictions and medical care options without the physicians worrying about retaliation from insurers; therefore be it

RESOLVED, that the WVSMA draft and petition the West Virginia Insurance Commissioner to promulgate an emergency rule prohibiting contract clauses that prevent physicians from freely discussing all treatment options with patients, whether or not the treatment options are covered by their plans.

Resolution 11 (Referred to Continuing Medical Education Committee)

WHEREAS, until recently, Domestic Violence, in its many forms, was considered to be a Social or Criminal Justice problem and not within the purview of the health professional, many victims continue to suffer adverse health consequences of Abuse, often resulting in death or permanent injury, and

WHEREAS, the financial impact of abuse is enormous in the health area, and

WHEREAS, many physicians are reluctant to routinely ask about physical and/or sexual abuse due to, in part, a lack of training in this area, or because of concerns about time constraints or privacy, or fear they will open a "Pandora's Box", which they are unable to handle; therefore be it

RESOLVED, that the Raleigh County Medical Society requests the WVSMA Continuing Medical Education Committee to recommend to those organizations in the state who have been accredited to Grant Category 1 CME Credit, that they include programs on Domestic Violence, both adult and pediatric, each year.

Resolution 12 (Referred back to Executive Committee and Council to be taken up at 1997 Annual Meeting House of Delegates)

WHEREAS, numerous people from WVSMA over the last several years have complained about high rates that The Greenbrier charges,

WHEREAS, after a long study by the executive committee comparing the rates of other locations,

WHEREAS, the Homestead has given us a proposal with daily room rates significantly less than are now being paid,

WHEREAS, numerous other states have their annual meeting in neighboring states and it is becoming a more accepted practice,

WHEREAS, for exhibitors there is no charge to the WVSMA for setup of the exhibits at the Homestead; therefore be it

RESOLVED that the WVSMA hold an annual meeting at the Homestead Resort and reassess the situation after that meeting has occurred.

Cancer Committee

The Annual Meeting of the WVSMA's Cancer Committee was called to order by Chairman Catalino B. Mendoza Jr., M.D., at The Greenbrier in White Sulphur Springs on Friday, August 23, 1996 at noon.

Members in attendance were: Drs. James P. Carey, Granciano E. Cendana Jr., Thomas Covey, Generoso D. Duremdes, John C. Frich Jr., and R. John C. Pearson.

Guests present were Leslie Given, state education coordinator for the Mary Babb Randolph Cancer Center, Cancer Education and Information Service. Also present from the WV Department of Health and Human Resources, Bureau for Public Health, were Nancye Bazzle, program director of the Cancer Control Program, and Robin Seaburg, Scott Dean, Dr. Cathy Slemp and Beverly Keener.

The minutes of the Annual Meeting held on August 19, 1994, were approved as issued.

Dr. Carey reported that the presentation of *"Smoking and Disease"* developed by the American College of Surgeons, Commission on Cancer, Cancer Liaison Physician Program, was well received by grades 6-9 in Huntington, and he recommended this presentation be continued.

Nancye Bazzle reported that the WV State Legislature appropriated $250,000 for the diagnosis and treatment of breast and cervical cancer for the indigent, and that these funds were made available July 1, 1996. Also, private and corporate donations may be made to the Breast and Cervical Cancer Diagnostic and Treatment Fund though the Greater Kanawha Valley Foundation.

Leslie Given announced that cancer and health education pamphlets and videotapes are available upon request from the Mary Babb Randolph Cancer Center, Cancer and Information Service, concerning treatment and prevention of various diseases.

Beverly Keener reported that the WV Cancer Registry's 2nd Annual Report on incidence and mortality rates for 1993-94 had been sent to providers. Occupational data on 1996 is forthcoming - - 2,000 questionnaires were sent out to physicians with a 20% response. She stated that 10 new cancer registries had been added in the state, making a total of 27 by the end of 1996. She commented on Title 64 of the WV Administrative Rules, Division of Health, Series 68, Cancer Registry, which establishes standards/procedures for reporting cancer cases to the cancer registry, for maintaining the confidentiality of data in the registry, and for disclosing data from the registry. She also reported that a QA review of the tumor registries in nine hospitals revealed an 80% compliance with a 95% completion rate.

Dr. Cathy Slemp announced that the cancer mortality rates for WV will be published in the January 1997 issue of the *West Virginia Medical Journal.*

Dr. Mendoza Jr. announced that the "Fall Cancer Conference: Improving Quality of Life - A Goal of Cancer Care" will be held on October 25 at the Robert C. Byrd Health Sciences Center in Morgantown. It was recommended by the committee that an announcement about the Fall Conference be published in the *WESGRAM.*

Dr. Mendoza Jr. stated that the next annual meeting will take place in August 1997 and that the place, time and date will be confirmed at a later date.

Council

Council Meeting - August 16, 1995

*The Financial report was accepted and approved. Two areas were reported in conjunction with this report:

1. Cost of Medicaid Litigation to date $119,208.
2. Blue Cross Liquidation $106,300.

*It was reported that membership had increased during 1995 by 8%.

*A report by Medical Assurance of WV showed a 16% increase in insured physicians compared to the number insured in 1994 under the previous endorsed malpractice insurer.

*The Medicaid Crisis Panel was discussed and efforts on the part of the WVSMA to inform panel members in our issues were outlined.

*The Alliance President's report discussed their efforts to increase membership.

*The AMA Field Representative gave an overview of the AMA's Medicare Cost Proposal.

*The Executive Committee report was accepted and approved.

*The Council approved retirement status for nine physicians.

Council Meeting - November 12, 1995

*Tom Sporck, M.D., WVSMA's representative on the Governor's Medicaid Crisis Panel gave an overview of the panel's actions. The panel reduced expenditures by $156 million primarily by cuts in reimbursements to providers. A number of recommendations not involving provider payments were made with the direction that the Health and Human Resources Department implement them if determined to be feasible.

*The financial report showed that revenues for 1995 were comparable to 1994. Expenditures were $95,240 less in 1995 compared to 1994. The report was accepted and approved.

*The Alliance president discussed their agenda for 1995-96 and thanked the WVSMA staff for their support in the production of 1996 *"Legislative Agenda"* video.

*The report of the Executive Committee was accepted and approved.

Council Meeting - January 21, 1996

The financial report showed revenue over expenses for 1995 to be $47,000. This was actually an increase of $96,000 over projections made for 1995 because it was anticipated that there would be a net loss of $49,000 for 1995. This was accomplished by reducing expenditures programmed for 1995. The report was accepted and approved.

The Alliance president gave a report and thanked the WVSMA for its support of the WVSMAA.

An overview of the 1995 Interim meeting of the AMA's House of Delegates held in December of 1995 was given by the chairman of the WVSMA's AMA delegation.

The Council approved four physicians for retired status.

A plea was made that Council members please return their attendance cards for Council meetings.

Three proposed changes to the Constitution & ByLaws of the WVSMA were referred to that committee for consideration. They were:

1. Term limits for AMA Delegates.
2. Not requiring two candidates for the offices of the WVSMA.
3. Two-year terms instead of the current one-year term for the speaker/vice speaker of the WVSMA House of Delegates.

The AMA Field Representative gave an overview of AMA activities at the national level.

Council Meeting - April 28, 1996

Due to the lack of a quorum the Council did not meet during the second quarter of 1996.

Committee on Medical Education

The West Virginia State Medical Association (WVSMA) is recognized as a provider to accredit intrastate continuing medical education programs by authorization through the Accreditation Council for Continuing Medical Education (ACCME). WVSMA has maintained this role since 1972.

Interest has been expressed in accreditation for sponsorship of CME Programs by: Cabell Huntington Hospital, Huntington; Man Appalachian Regional Hospital, Man; Monongalia General Hospital, Morgantown; St. Luke's Hospital, Bluefield. According to procedure, the following was sent to these organizations and hospitals interested in establishing CME accredited programs:

1.) Preliminary Questionnaire
2.) Application for Accreditation for CME Program
3.) Essentials and Guidelines
4.) Standards for Commercial Support of CME
5.) Standards for CME of Enduring Materials

An initial application was received from the Thomas Memorial Hospital and the survey completed May 16, 1996. The survey team consisted of Warren Point, MD, Anne Hooper, MD, Nancie Albright, and Shirleen Lipscomb. A one-year provisional accreditation status was granted.

An initial application was also received from the WVHA and the survey is being scheduled for September with John Traubert, MD, Elizabeth Spangler, MD, Nancie G. Albright, and Shirleen Lipscomb serving as surveyors.

The following reports have been submitted and these accredited organizations have been resurveyed since the last Annual Report:

Charleston Area Medical Center
Survey: October 12, 1995
Surveyors: Terry Elliott, MD, Ron Stollings, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Four-year accreditation with six-month report due in April and annual reports thereafter

VA Medical Center
Survey: October 16, 1995
Surveyors: James D. Helsley, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Four-year accreditation with annual reports

Jackson General Hospital
Survey: October 25, 1995
Surveyors: Warren Point, MD, Constantino Y. Amores, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Two-year accreditation with one-year interim report

WV Academy of Ophthalmology
Survey: November 8, 1995
Surveyors: Daniel Foster, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Two-year accreditation with annual reports

Bluefield Regional Medical Center
Survey: November 21, 1995
Surveyors: Graciano E. Cendana, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Two-year accreditation with annual reports

Wheeling Area CME
Survey: May 29, 1996
Surveyors: James D. Helsley, MD, Stephen Sebert, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Individual CME accreditation status for both institutions or one-year probationary as consortium

Weirton Medical Center
Survey: May 30, 1996
Surveyors: Terry L. Elliott, MD, Nancie Albright, Shirleen Lipscomb
Recommended Award: Four-year accreditation

St. Mary's Hospital
Survey: June 20, 1996
Surveyors: Daniel S. Foster, MD, Tim Allman, Shirleen Lipscomb
Recommended Award: Four-year accreditation

Beckley Appalachian Regional Hospital
Survey: July 31, 1996
Surveyors: Warren Point, MD, Keith Edwards, MD, Shirleen Lipscomb, Tim Allman
Recommended Award: Four-year accreditation

Monongalia Valley Association of Health Centers (Fairmont Clinic)
Two-year interim report received

Jackson General Hospital
One-year interim report received

Charleston Area Medical Center
Six-month report received

Davis Memorial Hospital
Six-month report received

Twenty-two institutions/organizations are accredited for Category 1 of the Physician's Recognition Award of the AMA by the WVSMA and these are as follows:

Beckley Appalachian Regional Hospital, Beckley, WV

Bluefield Regional Medical Center, Bluefield, WV

Broaddus Hospital/Myers Clinic, Philippi, WV

Charleston Area Medical Center, Charleston, WV

City Hospital, Martinsburg, WV

Davis Memorial Hospital, Elkins, WV

Fairmont General Hospital, Fairmont, WV

Jackson General Hospital, Ripley, WV

Mid-Ohio Valley CME, Parkersburg, WV

Monongahela Valley Assoc. Of Health Centers (Fairmont Clinic), Parkersburg, WV

Pleasant Valley Hospital, Point Pleasant, WV

Raleigh County Medical Society CME Program, Beckley, WV

Reynolds Memorial Hospital, Glen Dale, WV

St. Francis Hospital, Charleston, WV

St. Mary's Hospital, Huntington, WV

Thomas Memorial Hospital, South Charleston, WV

United Hospital Center, Inc., Clarksburg, WV

VA Medical Center, Martinsburg, WV

Weirton Medical Center, Weirton, WV

WV Academy of Ophthalmology, Charleston, WV

WV Academy of Otolaryngology, Charleston, WV

Wheeling Area CME Program, Wheeling, WV

The Committee continues to monitor each organization in its compliance with the Essentials and Guidelines and the Standards for Commercial Support and Enduring Materials set by WVSMA. To date, the CME Accreditation Director has attended all site visits as a source of continuity and uniformity in the application of standards for institutions/organizations. An effort is currently being made to educate other WVSMA staff members in conducting on-site surveys and, in this effort, both Shirleen Lipscomb and Tim Allman have attended national ACCME Workshops.

1996 Annual Reports were mailed in March to the Medical Education Committee for review, approval/disapproval or comments. A consensus was reached and a summary compiled. The regularly scheduled spring meeting of the Committee was canceled due to conflicting schedules. Therefore, the summary of these reports and comments was mailed May 30, to Committee members for their records and any further discussion will take place at the August Meeting.

The CME Workshop scheduled for May 23, 1996, was canceled due to the low number of registrants. It was later learned that many people had planned to register onsite, and several calls were received requesting that this workshop be rescheduled. It has been decided to coordinate another workshop in the spring of 1997, and market it for advance registration only.

A CME newsletter entitled *"CME Network Connections"* is being published quarterly to assist in keeping organizations across the state abreast of CME information. It is being mailed to all WVSMA accredited CME providers and their medical directors, the Medical Education Committee, and the WVSMA Executive Committee. It is also routinely mailed to both National organizations, ACCME and ACME as well as some contiguous states.

A new policy for consortia was approved and adopted at the January 20, 1996 meeting of the Committee. This policy was mailed to all WVSMA accredited organizations.

Nancie Albright was accepted as a National Accreditation Site Surveyor by the ACCME, and took the training for this position in Washington, DC in October 1995.

James Helsley, MD and Nancie Albright attended the 1996 National Leadership Conference, March 10-13, 1996, in Washington, DC.

Nancie Albright, CME Accreditation Director, completed two national surveys this year. The Iowa Medical Society with Thomas L. Pester, MD, on May 8, on behalf of the Committee for Review and Recognition of the Accreditation Council for Continuing Medical Education (ACCME). The resurvey took place in West Des Moines, Iowa. Ms. Albright completed an initial survey with Samuel Leonard, MD, for Allercare, Inc., a proprietary organization located in Ponte Vedra, Fla., for the Accreditation Review Committee of the ACCME, on July 8. Expenses for both surveys were paid by ACCME.

The Interim Report, required by the WVSMA 1995 Resurvey has been submitted to the ACCME.

REMINDER

The WVSMA/WV-ACP Mid-Winter Seminars and Scientific Conferences are coming soon!

Watch for Pre-conference Seminars to be announced

Mark These Dates!

January 16-19, 1997
Charleston House - Holiday Inn
Charleston, WV

Join us for:
- "Physicians and End-of-Life Decisions"
- "Physician/Public Session" - Physician/Patient Communication: How to Talk to Your Doctor
- "Controversies in Medicine"
- "Lunch and Learn" - S.A.V.E. (Stop America's Violence Everywhere)
- "Caring for the Chronically Ill: New Challenges Resulting from Medicine's Successes"
- "Potpourri of Topics"
- MDTV - offered again due to popular demand

1997 Mid-Winter Seminars and Scientific Conferences

January 16-19, 1997

Name _____

Address _____

City _____ State ____ Zip Code _____

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Payment by: __ Check __ Visa __ MasterCard

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Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
Lunch & Learn	**(Saturday, Jan. 18)**		
	physician	$50	____
	spouse/student	$35	____

If you have any questions regarding the conference, please contact our office staff at (800) 257-4747 or (304) 925-0342.

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

Special Report

Rational prescribing practices or how to avoid Board scrutiny

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DEBORAH LEWIS RODECKER, J.D.
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Editor's Note:
This article was originally published in November 1990 in the Journal. It is being reprinted at the request of the West Virginia Board of Medicine. The Board's current President is A. Paul Brooks Jr., M.D.

Like numerous other medical boards across the country, the West Virginia Board of Medicine has been requested by state physicians to provide information on the principles it uses to discipline physicians for inappropriate prescribing of scheduled controlled substances.

This interest on the part of physicians has been sparked as a result of several disciplinary actions which the Board has taken against physicians for overprescribing Scheduled controlled substances; primarily Schedule II controlled substances. This is not to say that problems have not occurred with controlled substances listed on Schedules III and IV, because they have been so identified and discipline has also been necessary in such cases. The primary problems, however, have been with the Schedule II controlled drugs such as Dilaudid, Tylox, Percodan, Percocet, perhaps Preludin, or Dexidrene.

What do the State Medical Practice Act and the regulations say about prescribing?

The Medical Practice Act states that professional discipline may be invoked if it is found that a practitioner has prescribed controlled substances other than in good faith, in a therapeutic manner in accordance with accepted medical standards and in the course of the practitioner's professional practice. Closely aligned with this is the Medical Practice Act prohibition on failing to keep written medical records justifying the patient's treatment, including test results, histories, examinations, etc.

The Board has found that problems with prescribing and the written records almost always go hand-in-hand. If a practitioner has well-documented medical records on patients, that fact tells the Board that the prescribing was done in the course of the practice, and whether or not done in good faith is a determination made in light of all the circumstances.

The question which most often puzzles physicians appears to be what are the "accepted medical standards?" There are no absolute, ironclad rules, of course. However, in several different administrative hearings over the past few years, the accepted medical standards have been described by medical experts, and the Board has adopted these concepts as follows:

-- The prescribing of Schedule II controlled substances should be limited to chronically ill patients, such as terminal cancer patients, and for a much limited period of use for persons suffering a severe or acute traumatic injury. In situations where patients are prescribed Schedule II drugs due to a severe, traumatic injury, it is not common to prescribe such highly addictive drugs for a period of more than two weeks. It is not in conformance with accepted medical standards to prescribe Schedule II controlled substances to patients in order that they will not seek these drugs illegally.

It is important to understand the discipline which the Board has found it necessary to impose has been related to (a) a pattern of controlled substance prescribing (b) in outpatient settings for (c) non-terminal chronic conditions (d) frequently with little or no documentation. In each of these cases, prescribing has been far outside a "range of reasonableness" (1).

Some examples of specific prescribing practices which the Board determined deserved discipline include:

1. Issuing prescriptions for large amounts of controlled substances at one time, (100, 200, or even 400 Dilaudid or Percodan at one time) and sometimes twice in one day.
2. Failing to keep accurate records on the prescribing of such substances and to monitor patients.
3. Prescribing to drug-dependent or addicted persons.
4. Failing to see and physically examine the patient while repeatedly providing drugs without adequate verification of need.
5. Prescribing with knowledge that family members were helping themselves to the patient's drugs.

6. Prescribing in spite of warnings from pharmacists that patients were getting similar drugs from other physicians.

Practitioners have also been disciplined for prescribing Schedule II anorectic drugs for weight loss. As in some other states, there is a Board of Medicine regulation prohibiting the prescribing of amphetamines or sympathomimetic amine drugs except for:

1. The treatment of narcolepsy; attention deficit disorder (a behavioral syndrome characterized by inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity); or drug-induced brain dysfunction;
2. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities;
3. The clinical investigation of the effects of such drugs or compounds when an investigative protocol has been submitted to, reviewed and approved by the Board before such investigation is begun.

In addition, Board of Medicine regulations specify that a physician may be disciplined by the Board for prescribing or dispensing any controlled substance for his/her personal use; or for the use of his/her immediate family when the physician knows or has reason to know that an abuse of controlled substances is occurring or may result from such a practice. Unfortunately, the Board has found it necessary to discipline several physicians for this activity.

Sometimes, when a physician gets in trouble with the Board for improper prescribing, the physician will tell the Board that he/she is going to cease prescribing Schedule II controlled substances entirely. This may not necessarily be the desirable response. There is a possibility that it is correct to manage a certain patient's chronic non-terminal condition with controlled substances. The Board fully understands the necessity for treating pain and suffering in a humane, intelligent manner. The Board does not tell physicians how to practice medicine.

What the Board does look for is whether the diagnosis of the patient is based simply on the patient's statements, or whether there is a history, a physical exam, and appropriate supporting data.

Is there a treatment plan reflecting the use of other types of treatment? Referral? Results of referral?

Is there adequate documentation of why other methods of treatment are not effective, and is there regular, real monitoring of the patient?

Is the physician recording every prescription with the correct amount of the drug prescribed and is there recognition of the potential for dependency?

All too frequently, the answers to these questions are utterly unsatisfactory and demonstrate that the physician for whatever reason is not using sound and reasonable professional judgment.

Many physicians do not realize they are major sources of drug diversion and that frequently the licit drugs they prescribe end up in an illicit market. The AMA National Steering Committee on Prescription Drug Abuse describes physicians who overprescribe controlled substances as falling into several categories: the dishonest, the disabled, the duped and the dated.

Dishonest physicians are those who willfully, knowingly prescribe controlled drugs for abuse and for profit. Disabled physicians are those whose professional competence has been impaired by drug abuse, alcoholism or other physical or mental abnormalities. Duped physicians are those who go along with patient demands for medication and prescribe in larger amounts or for longer periods of time than are medically indicated. Dated physicians are those who have not kept pace with developments in pharmacology or drug therapy. They lack information and understanding as to the harmful effects on the patient of their prescribing practices.

The Board has seen all of these types of physicians before it, as well as a fifth category: the distracted physician. This physician is simply not treating patients with adequate attention and has careless prescribing practices.

Some physicians appear before the Board and profess complete lack of awareness of the cost of a single Dilaudid tablet "on the street" (in the range of $50) and do not know that diverted Tylox capsules are a favorite for "snorting." They are unaware of frequent reports of all sorts of successful scams. Some of the scams involve elderly retirees who are recruited by drug rings to con Dilaudid prescriptions from trusting physicians. They are unaware that prescription drugs are identified in almost 60 percent of all drug-related emergency visits and in 70 percent of all drug-related deaths (2).

The Board has supplied the numerous physicians who have appeared before it with educational materials on the prescribing of Scheduled controlled drugs (3,4), and has recommended or required successful completion of a course in rational drug therapy and careful study of an AMA learning module on prescribing controlled drugs.

Despite these efforts, the number of physicians who have come to the attention of the Board has not diminished. It also recently has become evident that not all physicians are complying with the Board's dispensing regulations which became effective July 1, 1989. (For those physicians who lack enthusiasm about one or more set of regulations to follow, the Board was required to establish these rules and collect dispensing fees under the provisions of the Uniform Controlled Substances Act.)

In addition to reviewing the West Virginia Medical Practice Act and regulations, physicians may wish to review AMA Guidelines for

Physician Involvement in the Care of Substance Abusing Patients, which is available free from AMA's Department of Substance Abuse. Free subscriptions to Prescription Abuse Information Service are also available from the same department.

Finally, under the West Virginia Medical Practice Act and regulations, a physician may be disciplined for gross negligence in the use and control of prescription forms, and for pre-signing prescription forms.

Be careful with prescription pads. Sound advice is to treat them as you would your private checkbook (5). Maintain adequate security for those not in use and keep them in your personal possession when using them. If your DEA number is printed on your prescription forms, lock them up. Do not prescribe a controlled substance merely because a patient says another physician has been prescribing it. Be aware of the schedule on which a controlled substance is listed. Stay in control of your prescribing. Though you wrote the initial prescription, is your office staff permitted to provide refills?

The privilege of prescribing is a mighty one. Please, be prudent with this privilege. The Board takes no pleasure in prosecuting any physician for abusing and misusing this privilege.

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3. Seres JL. The rational management of the chronic pain patient. Federation Bulletin 1989; Jan: 25.
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5. Colorado prescription drug abuse task force report. Colorado guidelines of professional practice for Schedule II narcotic analgesics. February 1986.

Special Notice: Since the initial publication of this article in November 1990, the following notice was published in the *West Virginia Medical Journal* in October 1993:

Board of Medicine issues notice on methylphenidate

A rule of the West Virginia Board of Medicine (11 CSR 1A 12.1[ee]) provides that physicians may be disciplined by the Board for prescribing, dispensing, administering, supplying, selling or giving any amphetamine or sympathomimetic amine drug and a compound designated as a Schedule II controlled substance, unless such a drug is for narcolepsy, attention deficit disorder, drug induced brain dysfunction, depression, or clinical investigation when an investigative protocol has been submitted to the Board.

While methylphenidate is a compound designated as a Schedule II controlled substance and a sympathomimetic drug structurally related to amphetamine, methylphenidate is technically neither an amine nor an amphetamine. Therefore, the prescribing of methylphenidate is not restricted under West Virginia Board of Medicine Rule 11 CSR 1A 12.1(ee).

The Board understands that methylphenidate is prescribed by some physicians for the relief of pain and neuropsychiatric symptoms in the terminally ill, and wishes to clarify that physicians need not be concerned about the application of 11 CSR 1A 12.1(ee) to the prescribing of methylphenidate for such patients.

Special Notice: On September 9, 1996, the Board of Medicine adopted a Statement on Pain Management which is as follows:

The West Virginia Board of Medicine encourages appropriate pain management consistent with the West Virginia Medical Practice Act, its implementing rules, the article *"Rational Prescribing Practices or How to Avoid Board Scrutiny"* and the American Medical Association Council on Ethical and Judicial Affairs Code of Medical Ethics, 1996-1997, specifically opinions 2.20, 2.21 and 2.211.

Copies of the Statement on Pain Management with the opinions referenced in it may be obtained from the Board of Medicine by phoning (304) 558-2921.

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Work-up and management of patients with paradoxical emboli

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Abstract

Paradoxical embolism is defined as the passage of any material from the venous circulation into the systemic arterial tree via an abnormal communication which is accompanied by a right-to-left shunt. Although there are fewer than 40 reported cases, its incidence is probably much more frequent. This article describes our experiences treating six patients at Charleston Area Medical Center whose diagnosis of paradoxical emboli was based on the presence of Johnson's triad: (1) Venous thrombosis with/without pulmonary embolism, (2) An intracardiac defect with right-to-left shunting; and (3) Arterial embolism without a corresponding source in the left heart or proximal arterial tree. We conclude that paradoxical embolism should be considered in all patients with an unknown source of emboli, particularly young patients. If conventional M+2D echocardiography and peripheral angiography are inconclusive, further work-up should be performed with contrast saline echocardiography, transesophageal echocardiography, lung scan, and peripheral venous imaging.

Introduction

Although paradoxical embolism was first described by Cohnheim (1) in 1877, there have been fewer than 40 reported cases of paradoxical emboli diagnosed during life, but it is probably much more common. Meister et al (2) reported five cases which were diagnosed ante mortem and occurred over a two-year period with a variety of clinical manifestations. Chaikof et al (3) also reported six cases occurring over a five-year period.

In the past, the condition was usually diagnosed postmortem. The diagnosis may be difficult because of the variable nature of the systemic embolization, which can be presented as acute myocardial infarction, a cerebrovascular accident, acute mesenteric ischemia, or a peripheral vascular deficit.

According to Johnson (4), paradoxical embolism is considered proven when a venous thrombus is found lodged within an intracardiac septal defect at necropsy. A presumptive diagnosis may be based on the presence of:

(1) Venous thrombosis, with or without pulmonary embolism;
(2) An intracardiac defect which allows right-to-left shunt; and
(3) Arterial embolism without a corresponding source in the left heart or the proximal arterial tree. A favorable pressure gradient must exist at some time in the cardiac cycle for right-to-left shunting.

With the start of echocardiography, particularly transesophageal echocardiography, and the development of non-invasive maneuvers during imaging that define a patent foramen ovale (5,6), an accurate diagnosis of presumptive paradoxical embolism has been facilitated in patients with arterial embolism. In recent years, a subset of patients who present with arterial embolism has been identified in which no clearly definable cardiac or arterial source for the embolism is apparent. It is in this particular group of patients that paradoxical embolism must be considered and in whom the prevalence of this disease is likely to be much greater than previously considered (7).

This article analyzes our experiences treating six patients with paradoxical emboli.

Patients and results

Of 406 patients with a diagnosis of arterial emboli of the extremities treated at Charleston Area Medical Center during an eight-year period, six were discharged with a presumptive diagnosis of paradoxical emboli. There were three men and three women with an age range of 29 to 46 years, a mean of 39 years. Five patients had a clinical presentation of acute arterial ischemia of the lower extremity and one had acute ischemia of the right upper extremity.

The diagnosis of the arterial embolism was made by peripheral arteriography, which showed acute occlusion of the femoropopliteal segments in the lower extremity cases, as well as acute occlusion of the right brachial artery in the other patient. All peripheral arteriography showed a normal proximal and distal arterial tree, and all six cases

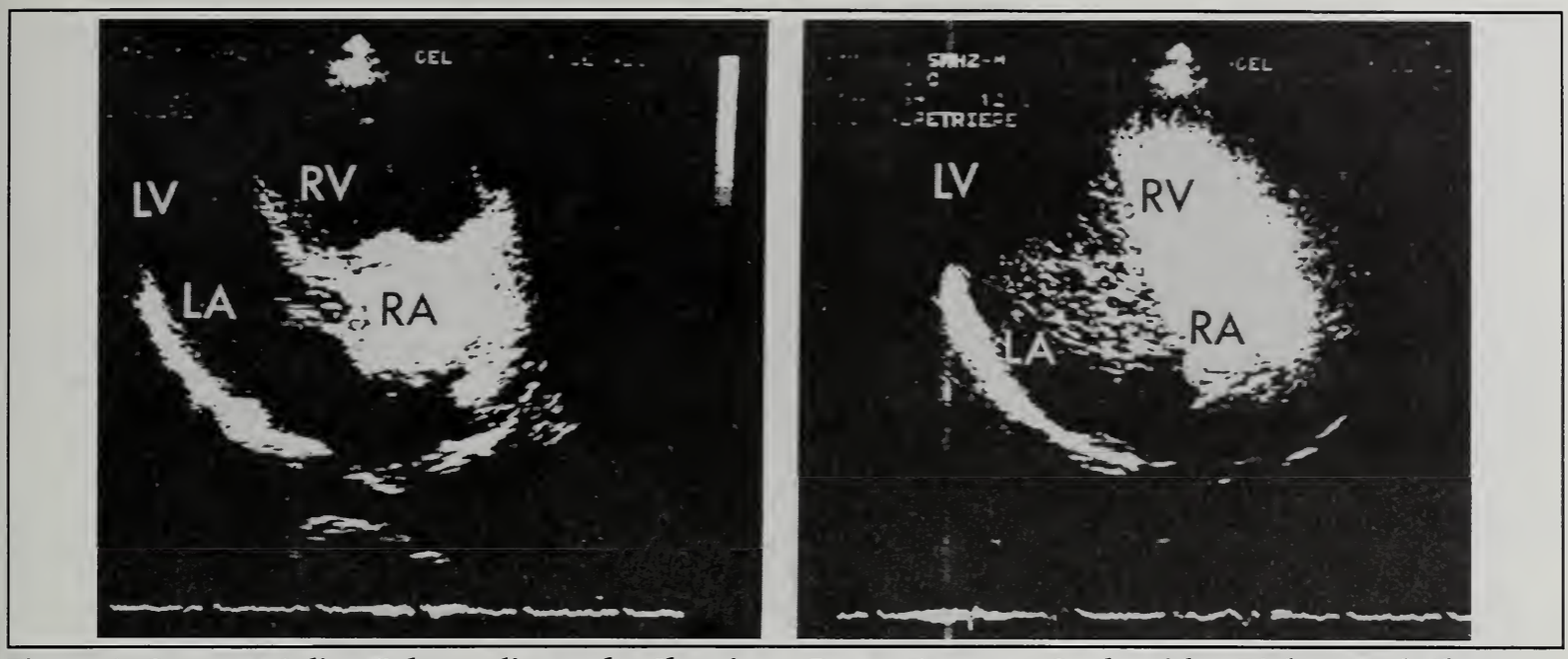


Figure 1. Contrast Saline Echocardiography Showing a Patent Foramen Ovale with a Right-to-Left Shunt When the Patient Coughs. Notice Micro Bubbles Appearing In Both Heart Chambers.

had concomitant deep vein thrombosis of the lower extremity or a past history of deep vein thrombosis that occurred two to three weeks prior to the acute onset of the arterial ischemia. The deep vein thrombosis was diagnosed by non-invasive methods (impedance plethysmography, venous duplex imaging, and/or venography).

Four of six patients had a positive lung scan for pulmonary emboli, one had a low probability for pulmonary emboli, and one had an inconclusive lung scan. Due to the presence of combined venous and arterial pathology, a preliminary diagnosis of possible paradoxical emboli was entertained. The final diagnosis was made after confirming the presence of an intracardiac defect (a patent foramen ovale) with right-to-left shunting upon Valsalva manuever or coughing. This was done on one patient based on a contrast saline echocardiogram (Figure 1), and by transesophageal echocardiography in three patients, and cardiac catheterization in two of the patients.

The treatment modalities utilized for these six patients included thromboembolectomy with long-term warfarin therapy in four patients, intra-arterial Urokinase therapy with long-term warfarin therapy in one patient, thromboembolectomy and repair of a cardiac defect with insertion of a Greenfield filter (following failure of warfarin therapy) to prevent further pulmonary embolization in one patient. All patients were alive and well at follow-up, which varied from 12 to 80 months.

First case report

A 29-year-old white male had developed a cold, painful right leg and foot. Past history included pain and tenderness of the left calf and a clinical diagnosis of deep vein thrombosis.

The clinical examination was unremarkable except for a pulseless, cold, pale right leg from the mid thigh down to the foot. Chest X-ray and EKG were unremarkable and M+2D echocardiogram was normal. Probable occlusion of the right femoral artery was identified by segmental Doppler pressures and deep vein obstruction of the left leg by a positive impedance plethysmography.

An arteriogram was interpreted as acute embolization to the right femoral and popliteal arteries with a normal proximal arterial tree. A venogram confirmed deep vein thrombosis of the left femoral popliteal veins. In addition, a ventilation and perfusion lung scan was inconclusive.

This patient was treated with intra-arterial urokinase thrombolysis with a successful outcome as confirmed by arteriography. His postoperative Doppler ankle/arm index was 1.0, in comparison to a pre-treatment index of 0.48. Contrast saline echocardiography was done which showed a patent foramen ovale with a right-to-left shunt on coughing (Figure 1). He was discharged on warfarin.

Second case report

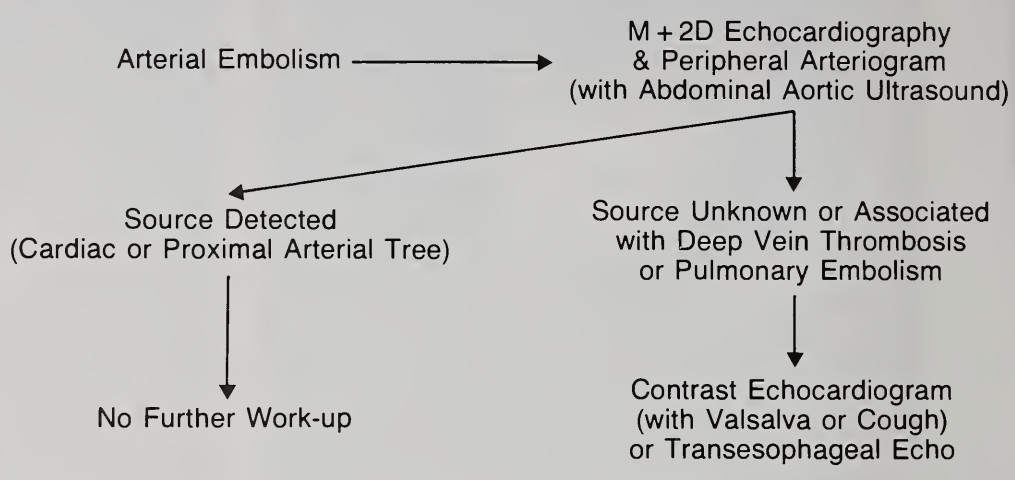
A 41-year-old white female was admitted because of a painful, cold, left lower extremity of four hours duration. Her past medical and surgical history was unremarkable except for a history of right calf and thigh pain, calf tenderness, and swelling three weeks prior to this admission.

This patient's physical exam was unremarkable except for absent pulses of the left lower extremity, cold left lower leg with decreased sensation, right calf tenderness, and positive Homan's sign. Her chest X-ray, EKG, and M+2D echocardiography were normal, but an arteriogram showed acute

embolization to the left femoral, popliteal, and tibial arteries, which was treated with an embolectomy. A venous plethysmography was positive for deep vein obstruction of the right leg which was confirmed by venography.

The postoperative course was uneventful, and she was discharged on warfarin. On a late six-month follow-up, she underwent a transesophageal echocardiogram which confirmed the presence of a patent foramen ovale.

Figure 2. Diagnostic Work-Up That Should Be Followed For Patients With Suspected Paradoxical Embolism.



Discussion

Paradoxical embolism is commonly defined as the passage of any material from the venous system into the systemic arterial tree through an abnormal intracardiac defect or vascular communication accompanied by a right-to-left shunt. This displacement of material is only possible in the face of increased right intracardiac pressures.

There are three prerequisites for the occurrence of paradoxical embolism:

(1) A right-to-left shunt or potential shunt must be present;
(2) Embolic material in the venous system (venous thrombus, septic material, air, or foreign bodies) must be present, and
(3) Thrombus must embolize to the arterial circulation. Patients may have an atrial or ventricular septal defect, a patent ductus arteriosus, or even an arterial venous malformation in the lungs.

However, the most common cardiac defect associated with paradoxical embolism is a patent foramen ovale. Thompson and Evans (8) examined a random series of 1,000 autopsies and found a pencil-patent foramen (.6 to 1.0 cm in diameter) in 6% of cases, while a probe-patent foramen (0.2 to 0.5 cm in diameter) was noted in 29%.

For a venous thrombus to cross a foramen ovale, a right-to-left pressure gradient must exist. The right atrial pressure may be elevated secondary to a chronic condition, as in obstructive lung disease with cor pulmonale, mitral stenosis (with pulmonary hypertension), tricuspid valve disease, or primary pulmonary hypertension. More commonly, the pressure gradient is caused by an acute process such as coughing, straining, or Valsalva maneuver.

The incidence of paradoxical embolism in the hospitalized adult population is difficult to assess due to the diagnostic difficulties in defining transient interatrial shunts and because many arterial emboli, particularly peripheral and occasionally cerebral, are clinically silent (9). One major group in which paradoxical embolism may have significant clinical impact is that of embolic stroke. Caplan et al (10) have demonstrated that 36% of 127 patients meeting a strict criteria for an embolic stroke had no identifiable intracardiac or arterial source.

While some of these patients were incompletely studied, the number of people with this common disorder suggests that as yet poorly defined pathophysiologic phenomena may be important contributing causes. Paradoxical embolism through a patent foramen ovale from a deep venous source in elderly sedentary patients during coughing or defecation may be one such mechanism for stroke in this group.

Lechat and colleagues (11), in a study of the prevalence of a patent foramen ovale in patients with a stroke, reported that the cause of ischemic stroke in younger adults is undefined in as many as 35% of patients. The prevalence of a patent foramen ovale was significantly higher in patients with a stroke (40%) than in the control group (10%). Among the patients with a stroke, the prevalence of a patent foramen ovale was 21% in 19 patients with an identifiable cause of their stroke, 40% in 15 patients with no identifiable cause but a risk factor for stroke, such as mitral valve prolapse, migraine, or use of contraceptive agents, and 50% in 20 patients with no identifiable cause. These results suggested that because of the high prevalence of clinically latent venous thrombosis, paradoxical embolism through a patent foramen ovale may be responsible for stroke more often than is usually suspected.

Clinically, the diagnosis of paradoxical embolism is presumptive, relying on circumstantial evidence. While the diagnosis is seldom made during life (8), it carries therapeutic importance. A high index of suspicion should be maintained in all instances of arterial embolism without clinical evidence of a source of emboli from the left side of the heart or the proximal arterial tree,

especially if either concomitant pulmonary embolism or venous thrombophlebitis is present. Contrast saline echocardiography performed with Valsalva's maneuver provides a safe, non-invasive method of demonstrating the presence of right-to-left shunting and thus a site for paradoxical embolism. Contrast echocardiography should also be done in all young patients with arterial emboli, even if all other cardiac findings and studies are normal.

In many of the patients with a patent foramen ovale, right-to-left shunting could not be demonstrated without provocative maneuvers to transiently increase right atrial pressure. The Valsalva maneuver and coughing are two means by which transient increases in right-sided pressures may be produced.

Several reports have shown that contrast echocardiography is useful for the detection of intracardiac right-to-left shunts (12,13). Various contrast agents, including indocyanine green, dextrose water, normal saline solution, or the patient's own blood can be used since the contrast effect is most likely similiar to the microcavitation bubbles which are produced in the blood during rapid injection of the contrast medium (14).

Microcavitation bubbles reflect sound waves, thus producing a contrast effect as viewed with two-dimensional and/or M-mode echocardiography. The Valsalva maneuver has been used to detect small defects in the atrial septum (15). Release of the Valsalva maneuver poses transient reversal of the normal resting intra-atrial pressure gradient, and pressure in the right will exceed that in the left atrium.

Contrast echocardiograms are usually obtained using an apical four-chamber view and a rapid injection of 10 ml of agitated sterile normal saline through a peripheral IV cannula. At least four saline injections are performed and recorded on each patient. All injections are made during normal quiet respiration and following Valsalva maneuver. A contrast echocardiogram is considered positive if micro bubbles appear either in the left atrium or left ventricle no later than two to three cardiac cycles after initial appearance in the right atrium (Figure 1). Recently, transesophageal echocardiography has been used for the diagnosis of paradoxical embolism (6,16,17).

The diagnosis of paradoxical emboli should be considered in any patient with an unexpected arterial embolism. Although simultaneous pulmonary embolus is indicative of paradoxical embolus, it is not a prerequisite. In some patients the pulmonary embolism may be undiagnosed, and an arterial source for the embolus will be sought, but to no avail. Demonstration of the right-to-left shunt is often difficult. If the patient is studied after the event, the pulmonary embolus may have dissolved, with a return of the right atrial pressure to normal. Cardiac catheterization, which is one method of demonstrating such a cardiac defect, may be unrevealing.

The differential diagnosis of arterial embolism in patients with temporally associated deep vein thrombosis or pulmonary embolism includes:

(1) Paradoxical embolism;
(2) Primary cardiomyopathy with mural thrombi in both sides of the heart;
(3) Acute myocardial infarction with mural thrombi in the left ventricle, occurring concurrently with pulmonary emboli from peripheral veins;
(4) Emboli related to prosthetic replacement of mitral, aortic, and/or tricuspid valves;
(5) Emboli arising from infected endocarditis involving both left and right sided cardiac valves; and
(6) Emboli from myxomas of both right and left atria.

In patients with cyanotic congenital heart disease and arterial embolism, paradoxical embolism is extremely likely. In all patients, however, the diagnosis is more difficult to confirm. Until the advent of contrast echocardiography and/or transesophageal echocardiography, cardiac catheterization was the only pre-morbid method available to define transient intra-cardiac shunting. The safety and accuracy of defining intra-cardiac shunting through the foramen ovale has been greatly improved by the use of contrast echocardiography.

In view of the new diagnostic studies that are now available, a reasonable diagnostic approach to patients with suspected paradoxical embolism is outlined in Figure 2.

Various treatment strategies have been employed to manage cases of paradoxical embolism. Throughout the 1970s, most investigators recommended surgical interruption of the inferior vena cava as the treatment of choice. However, in 1981 Leonard et al (7) suggested immediate anticoagulation with heparin because they believed that vena cava interruption should be undertaken only in patients with permanent right-to-left shunts. If the site of the emboli is not in the brain, then thrombolytic therapy should be considered.

While no single approach can be overwhelmingly endorsed for all patients, a multifaceted approach to treatment should be considered. If no contraindication to anticoagulation exists, 10 days of intravenous heparin therapy followed by three to six months of warfarin therapy is recommended. If significant acute cor pulmonale develops as a result of acute pulmonary embolism or if peripheral arterial obstruction from embolism jeopardizes limb viability, thrombolytic therapy should be considered if feasible.

If a contraindication exists for anticoagulant or thrombolytic therapy, then an inferior vena cava interruption is recommended and peripheral and/or pulmonary embolectomy should be attempted as hemodynamic compromise dictates. Peripheral arterial embolectomy is to be done as indicated. In rare cases in which an impending paradoxical embolism is noted on echocardiography, intracardiac embolectomy may be attempted. Correction of intracardiac defects should be based on the generally accepted indications for repair.

Conclusions

In conclusion, paradoxical embolization should be considered whenever unexplained arterial occlusion occurs, particularly in younger patients. The work-up of these patients should include a lung scan, venous duplex imaging of the lower extremity, and a complete cardiac work-up, and/or peripheral venogram.

If the M+2D echocardiography, peripheral arteriogram, or abdominal aortic ultrasound do not show the source of emboli, contrast saline echocardiography or transesophageal echocardiography should be done.

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The effect of severe closed head injury on the incidence of nosocomial infections

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Abstract

Severe closed head injury is a common problem seen with trauma patients. These patients often develop infections that seem unrelated to their injury. This article describes our experiences evaluating the contribution of head injury to infection rates as compared to severe trauma without head injury. We conclude that infection rates in patients with severe closed head injury are equivalent to similarly injured patients without head injury.

Introduction

There have been many recent studies which have shown that certain facets of the immune system become depressed after severe trauma. This may be related to the 50%-75% incidence of nosocomial infection in these patients, and, in fact 78% of all late deaths following trauma can be accounted for from sepsis which may be a direct result of initial trauma related to immune suppression (1,2).

Studies investigating immune competence in trauma victims have focused on two patient populations - - patients with severe closed head injury (SCHI) and patients with multiple trauma with no specific reference to severe head injury. Since the rate of nosocomial infections seen in SCHI patients is 50%-75%, it is second only to electrolyte abnormalities for common extracranial complications after severe head injury (3,4). These patients have been shown to have a variety of defects in cellular immune competance after injury which may contribute to the high rate of infection (3).

In trauma patients with multiple injuries, infection rates have been shown to be in the same range with similiar defects in cellular immunity (5). There has been no study comparing the difference in infection rates of trauma patients with and without SCHI that have been equalized for injury severity. The purpose of this study was to compare infection rates (clinically relevant immune dysfunction) between patients with SCHI and thos e with multiple systemic injury in the absence of SCHI with equivalent severity of injury. We defined SCHI patients as those with Glasgow coma scores of 8 or less. This reproductive clinical study is designed to delineate differences in nosocomical infection rates between patients with SCHI and those with severe trauma alone.

Materials and methods

A retrospective chart review was performed on 39 consecutive SCHI patients and 32 consecutive control patients (those with multiple trauma excluding SCHI) admitted to the trauma service at West Virginia University Hospitals from July 1, 1993 to July 15, 1994. The patients were selected with West Virginia University Hospital's trauma data base.

The charts were reviewed for age, length of hospitalization, injury severity, via the injury severity score as defined by Baker et al (6), Glasgow coma score upon presentation into the trauma bay, gender, mechanism of injury, survival, and presence of infection during hospitalization. The entry criteria for the SCHI patients was a Glasgow coma score of 8 or less at the time of arrival to the trauma bay, no open cranial wounds, an injury severity score of at least 20 and a hospital stay of at least three days. The entry criteria for the control group patient population were the same with the exception that they required a Glasgow coma score on admission of 9 or more.

The standard microbiologic and clinical criteria used for diagnosing of infections are listed below:

Pneumonia - Presence of fever, leukocytosis, new infiltrates on chest roentgenograms, diagnostic Gram stains, and cultures.

Sinusitis - Presence of fever, leukocytosis, purulent nasal drainage with new opacification of the involved sinus on sinus series roentgenograms or CT scans, diagnostic Gram stains, and cultures.

Meningitis - Fever, leukocytosis, typical clinical signs with low glucose levels in the cerebrospinal fluid, and diagnostic CSF cultures.

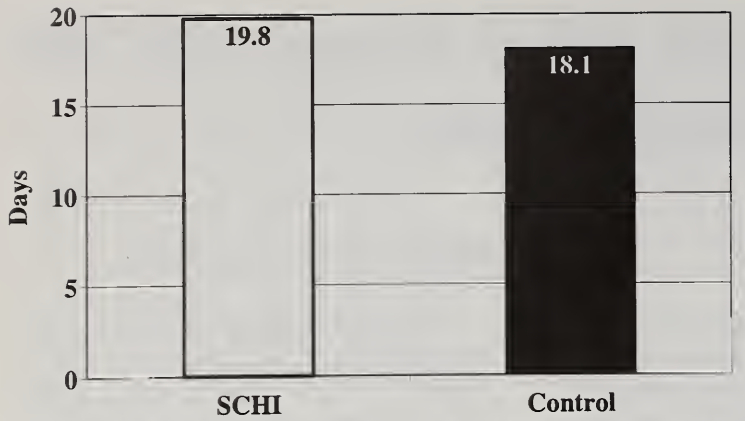

Figure 1. Average length of stay in the hospital for both the severe closed head injury (SCHI) patients and the patients in the control group.

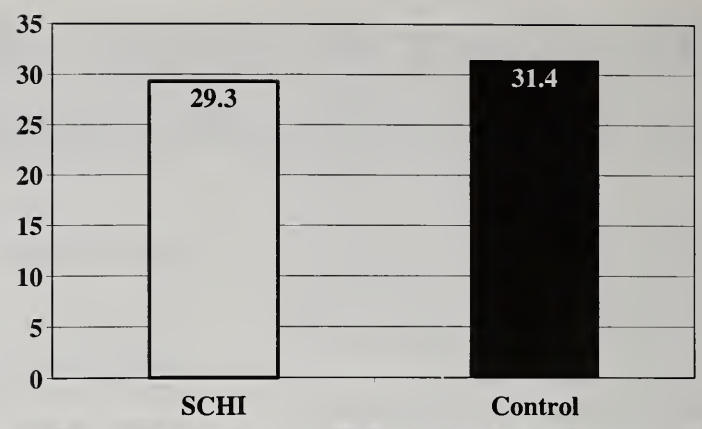

Figure 2. The average injury severity score of the control group as compared with the average injury severity score of the study group.

Septicemia - Presence of fever, leukocytosis, unstable vital signs with a high cardiac output index and low systemic vascular resistance, and diagnostic CSF cultures.

Data from both patient populations were entered into a computerized database. Statistical comparisons between control and SCHI patients were done using ANOVA with a statistical software package. Statistical significance was assumed at $p < .05$. Data are expressed as percentages and means.

Results

The mean ages of the control and the SCHI populations were 37.3 and 28.6 respectively. In addition, the gender distribution was similiar for both populations, with 27 males and 12 females in the SCHI group, and 22 males and 10 females in the control group.

Although the average length of stay in the hospital was 1.7 days fewer for the control group as compared to the head injured patients, this was not significant (Figure 1). The average injury severity score of the control group was 31, compared with the study group average which was slightly lower at 29.3 (Figure 2).

As defined by this study, the control group's average Glascow coma score was much higher than that of the study population. Average GCS for the control group was 14.2 versus 4.2 in the head injured patients.

Auto accidents were the most common cause of injury in both groups, accounting for 65% in the control group and 55% in the study population. Other major mechanisms of injury included motorcycle accidents and falls (Table 1).

Control patients had a survival rate of 96%, which is comparable to the 89% survival rate seen in the head injured patients (Figure 3). The rate of infection found in the control group was 50% which was slightly less than than the 66% infection rate in the study group (Figure 4). Although the infection rate percentage was higher in the SCHI group, it was statistically insignificant.

Discussion

Depression of the host response to invasive infection occurs in both severe neurologic injury and severe multiple trauma (3,4). In fact, many key factors involved in the immune system have been shown to be defective after multiple trauma.

Various facets of cellular immunity have been extensively studied in both SCHI and multiple trauma patients. They have been shown to have multiple defects including increased suppressor cell activity, decreased receptor expression, and decreased proliferative response (2,3,11).

Quattroochi and colleagues have shown that cell-cell signaling capacity (cytokine levels) of peripheral blood lymphocytes is markedly decreased after severe head injury when compared with normal control subjects (3). Livingston and colleagues found similiar results regarding cellular immunity up to 21 days post injury in severe multiple trauma (4).

Inability to produce cytokines and failure to amplify a recognition signal of foreign antigen are common factors in both populations (7-13). This deficiency of a microendocrine system may be the critical reason for the lack of immune competence.

Table 1. Mechanisms of Injury in the Control and SCHI Patients.

Mechanism of Injury	*Control Group*	*SCHI*
1. Motor vehicle crash	21	22
2. Motorcyle crash	3	3
3. Fall	1	5
4. Other	7	9
Total	32	39

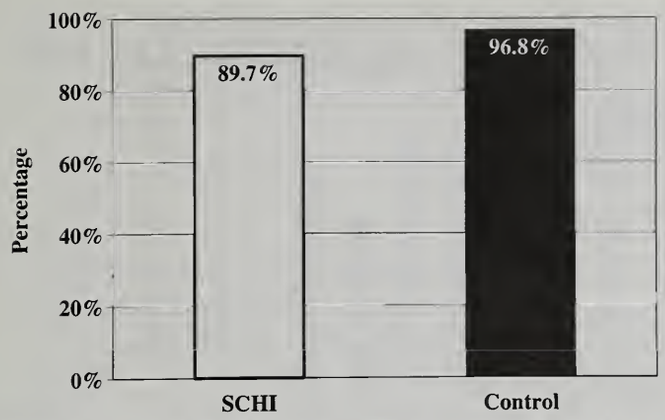

Figure 3. Survival rates of the SCHI and control patients.

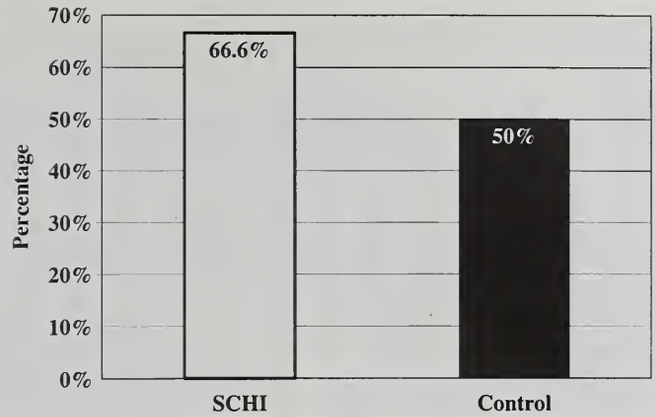

Figure 4. Infection rates of the SCHI and control patients.

Conclusions

Our study evaluated differences of nosocomial infection between patients with SCHI and patients with multiple trauma but no specific reference to severe head injury. Our results indicate multiple trauma with SCHI does not appear to increase susceptibility to infection more than trauma alone without neurologic injury.

Even though we reached this conclusion, there are considerations that need to be investigated. Specific aspects of immune dysfunction must be identified. The biggest problem seems to be at the antigen processing and presenting level with cytokine signal generation. Immune enhancement using growth factors (e.g. granulocyte colony stimulating factor) (13,14) or supplemented diets (e.g. multi-component diets with arginine w-3 fats, RNA) (15-18) may be appropriate therapy, and further studies are underway.

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All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 1). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in solid black or pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Medialization laryngoplasty for the treatment of unilateral vocal cord paralysis

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Abstract

Medialization laryngoplasty has emerged in the last decade as an alternative to teflon injection for the treatment of vocal cord paralysis. The advantages of laryngoplasty include the reversibility of the procedure, the ease with which it is performed, and in experienced hands, excellent voice results. This article describes a study of 29 patients at West Virginia University Hospitals from 1990 to 1994 who underwent medialization laryngoplasty. Of these patients, 24 had good or excellent results, including one patient who required a revision. All patients with aspiration or choking had marked improvement in swallowing, choking, or aspiration. One patient required intubation for 24 hours, and none of the prostheses have extruded. We conclude that medialization laryngoplasty is an easier procedure than teflon injection, and that it preserves the vocal cord mucosal wave.

Introduction

Surgical treatment of unilateral vocal cord paralysis has varied over the years since 1911 when Brunings (1) used laryngeal injection techniques for the treatment of glottal insufficiency.

In 1915, Bayr (2) first described medialization of the vocal cord utilizing laryngeal framework surgery. Teflon injection, however, became the treatment of choice in the U.S. after it was reported by Arnold (3) in 1962. Then, after Isshiki (4,5,6) described the thyroplasty I technique in 1974, this procedure began to emerge as an alternative to teflon injection for the treatment of vocal cord paralysis or atrophy.

Opponents of the teflon injection technique argue that it is technically difficult and requires a great deal of patient cooperation. Results are unpredictable. Most importantly, though, it is irreversible, and may cause damage to the body-cover relationship (7).

Materials and Methods

Ninety-eight patients with unilateral vocal cord paralysis from August 1990 to June 1994 were seen at West Virginia University Hospitals. Of these patients, 29 (30%) needed medialization laryngoplasty.

The 22 men and seven women ranged in age from 39 to 83 years (mean: 63 years). Twenty-three patients had left vocal cord paralysis, while 6 patients had right vocal cord paralysis. The cause of the paralysis was neoplasm in 11 patients, trauma in three patients, iatrogenic in nine, and in the remaining six patients the cause was idiopathic (Table 1).

Preoperatively, moderate to severe aspiration was experienced by 23 patients, and five had recurrent pneumonia with hospitalizations. All patients had preoperative voice evaluation with videostroboscopy, determination of maximum phonation time, and a local mini-compression testing (8). A modified Isshiki medialization laryngoplasty was performed on all 29 patients; two of the patients also had an arytenoid adduction procedure. All procedures were done under local, monitored anesthesia in the OR. One patient had a previous procedure, and needed revision.

The surgery was performed with the patient supine, and the neck prepared and draped in the usual manner. The incision site was infiltrated with Xylocaine 2% and Epinephrine 1:100,000. A 5 cm transverse skin incision, preferably in a skin crease, was made between the thyroid notch and the cricoid cartilage. Skin flaps were elevated in a subplatysmal layer superiorly and inferiorly. The mid-line raphé of the strap muscles was identified and incised.

Next, strap muscles on the side of the paralysis were elevated and retracted laterally. The height and width of the thyroid ala were then measured, and the size and location of the cartilage window were determined using the following formula (9):

$$\text{window height (mm)} = \frac{\text{Thyroid alar height (mm)} - 4}{4}$$

$$\text{window width (mm)} = \frac{\text{Thyroid alar width (mm)} - 4}{2}$$

The window was then placed 5-6 mm lateral from a point midway between the thyroid notch and the inferior border of the thyroid cartilage. The direction of the window in the thyroid ala is parallel to the inferior border of the thyroid cartilage. A #11 blade was used to

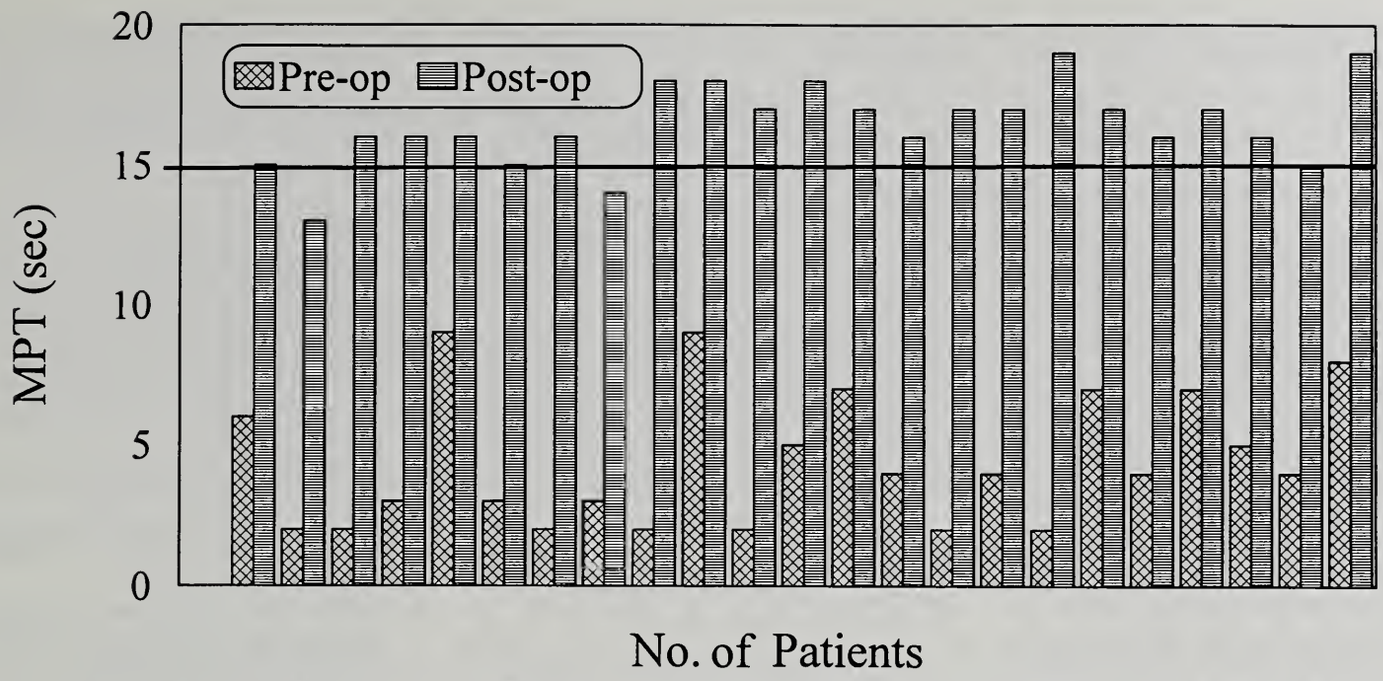

Figure 1. Bar Graph of Preoperative and Postoperative Maximum Phonation Time (MPT) of the 23 Patients Who Had Medialization Laryngoplasty at WVU Hospitals (Lower Normal Limit of MPT = 15 Seconds).

make an incision in the cartilage; however, if the cartilage is ossified, an oscillating saw should be used.

Once the window had been defined, the piece of cartilage was removed and the depth of the implant determined. A silastic implant was then fashioned and inserted. No sutures were used to hold the implant in place. After a Penrose drain was inserted, the wound was closed.

During the procedure, the vocal cords were constantly observed with a flexible larynscope to define optimal medialization. Inspection of the vocal cords allowed us to note any laryngeal edema.

Results

Follow-up was available on 27 of the 29 patients. In addition, one patient underwent a revision for a previously failed medialization procedure.

Of the 27 patients, 24 had improved voices (including one patient who did not initially improve and underwent a subsequent revision with an arytenoid adduction procedure).

Preoperative and postoperative maximum phonation times were available for 23 patients and the results showed that 21 patients had a normal maximum phonation time after surgery. However, two patients who experienced voice improvement, did not have a normal maximum phonation time (Figure 1).

Twenty-three patients had complained of preoperative aspiration, while only two continued to have aspiration postoperatively. Five patients had a preoperative history of recurrent pneumonia; postoperatively, only one patient did so, and she was 79 years old and had metastatic histiocytic lymphoma to the lungs.

Complications

Four of the 29 patients experienced complications.

One woman had airway obstruction after a medialization laryngoplasty and arytenoid adduction which required intubation for 24 hours. She was well until seven hours postoperatively when she began to experience dyspnea. Flexible laryngoscopy revealed that the left false cord was severely edematous and ecchymotic, and the supraglottic airway severely obstructed. She was intubated with little difficulty. After 24 hours she was extubated. Her voice was good with a normal maximum phonation time postoperatively.

A second patient required a revision after migration of the implant caused recurrence of symptoms. In that patient, the initial implant had been placed on the cartilage to medialize the cord. A third patient had a wound infection which was treated medically as an outpatient. The last patient had delayed wound healing.

In all of the patients, there were no implant extrusions, no hemorrhages or bleeding in the neck, and no deaths.

Discussion

Medialization laryngoplasty is rapidly becoming the treatment of choice for symptomatic unilateral vocal cord paralysis. The quality of the voice that is obtained is remarkable.

All of our patients tolerated the procedure under local monitored anesthesia. Minimal discomfort was experienced. Monitoring by flexible laryngoscopy and the fact that the patient was awake allowed fine tuning of the voice. This result is not possible under general anesthesia during teflon injections since most patients are very uncomfortable.

Another advantage of medialization laryngoplasty is that it can be performed earlier because the procedure is potentially reversible. Removal of

the silastic was extremely simple in our two patients who needed revisions. There was no scarring, and the implant was easily removed. These revisions were carried out at about three and six months postoperatively. On the other hand, arytenoid adduction as described by Isshiki (11), is irreversible and should not be performed unless there is evidence of complete denervation.

In previous series (5,9,10), success rates after medialization laryngology have been reported to be between 84% and 91%. In our series, 24 out of 29 patients (89%), including the one who required revision, had excellent voice results. All 23 patients had marked improvement in swallowing with no episodes of choking or aspiration of which they had complained preoperatively.

Another symptom in our series that is not often discussed in the literature is aspiration pneumonia. Five of our patients had experienced at least one episode of aspiration pneumonia and several had required multiple hospitalizations. Four out of the five had complete resolution of the problem. The remaining patient had fewer episodes of pneumonia. The success rate is similar to if not better than that of teflon injection.

As reports of the success of medialization laryngoplasty continue, and with further refinements in technique, it will become the treatment of choice in carefully selected patients with unilateral vocal cord paralysis.

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Deoxyribonucleic acid flow cytometry of squamous cell carcinoma of the penis

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Abstract

Squamous cell carcinoma of the penis is an uncommon but potentially fatal malignancy, especially in the presence of inguinal lymph node metastases. The morbidity of inguinal lymphadenectomy precludes its use as a staging procedure on all patients, and the inability to predict which patients will progress to nodal disease remains a difficult problem. This article describes our use of deoxyribonucleic acid flow cytometry on paraffin-embedded specimens of 17 consecutive patients with histologically-diagnosed squamous cell carcinoma of the penis. Our results suggest that patients with squamous cell carcinoma of the penis and a high DNA index may be at an increased risk of disease progression and therefore may be candidates for aggressive surgical management, and also suggest that DNA flow cytometry may be a reliable prognostic indicator for selecting which patients would benefit most from inguinal lymphadenectomy.

Introduction

Carcinoma of the penis represents 3% of all genitourinary malignancies and has an overall incidence in the United States of 0.1/100,000 years old (1-4). The median age at the time of presentation is about 67 years and over 99% of all carcinomas are of squamous origin (5,6).

According to the Jackson Staging System for penile cancer, the presence of palpable inguinal lymph nodes after resection of the primary lesion signifies advanced disease (Stage III and IV) (Table I), which is significant when considering that prognosis directly correlates with tumor stage (7-10). Specifically, five-year survival for patients with nodal disease is only 40% versus 90% for Stage I and 65% for Stage II disease, respectively (1,3,8).

Since Fraley et al have shown that nearly all patients who die from metastatic disease had their first metastasis within inguinal lymph nodes, lymphadenectomy has become an important consideration in the treatment of penile carcinoma (9). Yet in defining which patients would benefit most from lymph nodal dissection, many authors have noted that up to 50% of patients with palpable inguinal nodes have no histologic evidence of nodal disease and approximately 20% of patients with no palpable nodes actually have microscopic metastases (8,11-13).

In view of the 30% morbidity rate after inguinal lymphadenectomy due to lymphedema, thrombophlebitis, thromboembolism, flap necrosis and wound infection, these high rates of staging make it difficult to follow the recommendation of some authors that all patients with invasive penile carcinoma should undergo routine inguinal node dissection (8,10).

In an attempt to enhance patient selection for lymphadenectomy and therefore decrease the morbidity of potentially unnecessary node dissections, Cabanas et al developed the concept of "Sentinal Node" biopsy from a group of nodes located at the anteromedial aspect of the superficial epigastric vein at its union with the saphenous vein (14,15).

This concept was based on the belief that this nodal group was the first site of micrometastases and the presence or absence of disease would predict the need for further inguinal node dissection (14). Since then, other authors have shown significant false negative results with this technique, thus leaving its reliability in doubt and unanswered the questions of how to predict which patients will benefit most from inguinal lymphadenectomy because of their high risk for nodal metastases (16,17,13,18,19).

In an attempt to address this question, we present the results of our correlation of DNA ploidy status with tumor stage and prognosis in 17 patients with squamous cell carcinoma of the penis.

Materials and methods

Paraffin-embedded specimens of 17 consecutive patients with histologically diagnosed squamous cell carcinoma of the penis between 1977 and 1988 were sectioned into several 250 micron sections and dewaxed in xylene with constant rotation at 37C for 18 hours.

Each specimen was then rehydrated twice with 95% and 70% absolute ethanol for 10 minutes at room temperature, washed in distilled water and suspended in pepsin for two hours at 37C under constant rotation. The pepsinized tissue was then centrifuged for five minutes, the supernatant was resuspended with 0.1% nonident P-40 (500 microliters) for five minutes at 4C and RNase was added and the mixture was incubated at 37C for 20 minutes.

One cc of propidium iodide staining solution was then added and incubated at 4C for 60 minutes (20,21,22,23). Each stained specimen was then subjected to flow cytometric DNA analysis and DNA histograms as well as DNA indices (DNA index of DNA peak in reference to human diploid peripheral blood mononuclear cells) were obtained in 13 patients.

Four unsatisfactory histograms were obtained secondary to the paucity of available tissue after dewaxing. Each patient's histogram was retrospectively correlated to tumor stage at presentation and patient survival in months.

Table 1. Jackson Staging System for Penile Carcinoma

Stage I:	Tumor limited to glans penis or prepuce.
Stage II:	Tumor invasion into the penile shaft or corporal bodies with negative lymph nodes.
Stage III:	Tumor confined to the anatomic penis but with documented nodal disease.
Stage IV:	Tumor growth beyond the penis with distant metastases and/or inoperable nodal disease.

Results

At presentation, eight of the 13 patients had Stage I disease, two Stage II and three Stage III disease. Only one diploid histogram was obtained and this patient survived 48 months without disease progression and died of unrelated causes.

Of the 12 aneuploid histograms, two were hypodiploid. These patients were Stage I and remain alive and disease free at a mean of 27 months with a mean DNA index of 0.80.

Of the 10 patients with hyperdiploid histograms, seven are alive and disease free at a mean of 82 months with a mean DNA index of 1.60. Three patients died of disease progression at a mean of 29 months with a mean DNA index of 2.35.

Overall, three of five patients with a DNA index above 1.75 died of disease progression, and no patient with a DNA index less than 1.75 suffered progression, a difference which is statistically significant ($P = 0.035$, Fisher's exact). Suprisingly though, while disease progression was predicted, there was no correlation of DNA index or ploidy status with disease stage at the time of initial presentation.

Discussion

The poor prognosis associated with nodal metastasis underscores the importance of determining which patients with squamous cell carcinoma of the penis will develop lymph node metastases (3,7,8,11). While inguinal lymphadenectomy is the only definitive method to diagnose nodal disease, it is associated with a morbidity of up to 30%, including disabling lymphedema, thrombophlebitis, thromboembolism, wound infection and skin flap necrosis (8,11,12,13).

It is not surprising then that the concept of sentinal node biopsy proposed by Cabanas et al and later advocated by Fowler et al is an appealing alternative for predicting which patients would benefit most from inguinal lymphadenectomy (14,15). However, as demonstrated by Perinetti, as well as by Wespelet et al and deKernion et al, this method may be associated with a significant false-negative rate and is therefore not a completely reliable means for defining the incidence of metastatic nodal disease (13,17,18).

In the absence of a reliable prognostic indicator in patients with squamous cell carcinoma of the penis, we proposed correlating patient survival and tumor stage to DNA flow cytometric analyses of tissue specimens (24,25). Overall, three patients died from disease progression, and all had hyperdiploid histograms with a mean DNA index of 2.35. This compares unfavorably to the remaining seven hyperdiploid patients who had a mean DNA index of 1.60 and who all remain alive and without evidence of disease progression at a mean of 82 months.

In attempting to define a threshold for disease progression, we note that all three deaths involved patients with a DNA index above 1.75 and that no patient with an index below 1.75 suffered progression, a difference which is statistically significant ($P = 0.035$, Fisher's exact). Surprisingly, there was no correlation of DNA index with disease stage at the time of presentation.

Conclusion

In summary, our data suggest that patients with squamous cell carcinoma of the penis and a high DNA index may be at an increased risk of disease progression and therefore may be candidates for aggressive surgical management.

The data also suggest that DNA flow cytometry may be a reliable prognostic indicator in patients with squamous cell carcinoma of the penis, although further study in a larger patient population will be needed before any definitive conclusions can be made.

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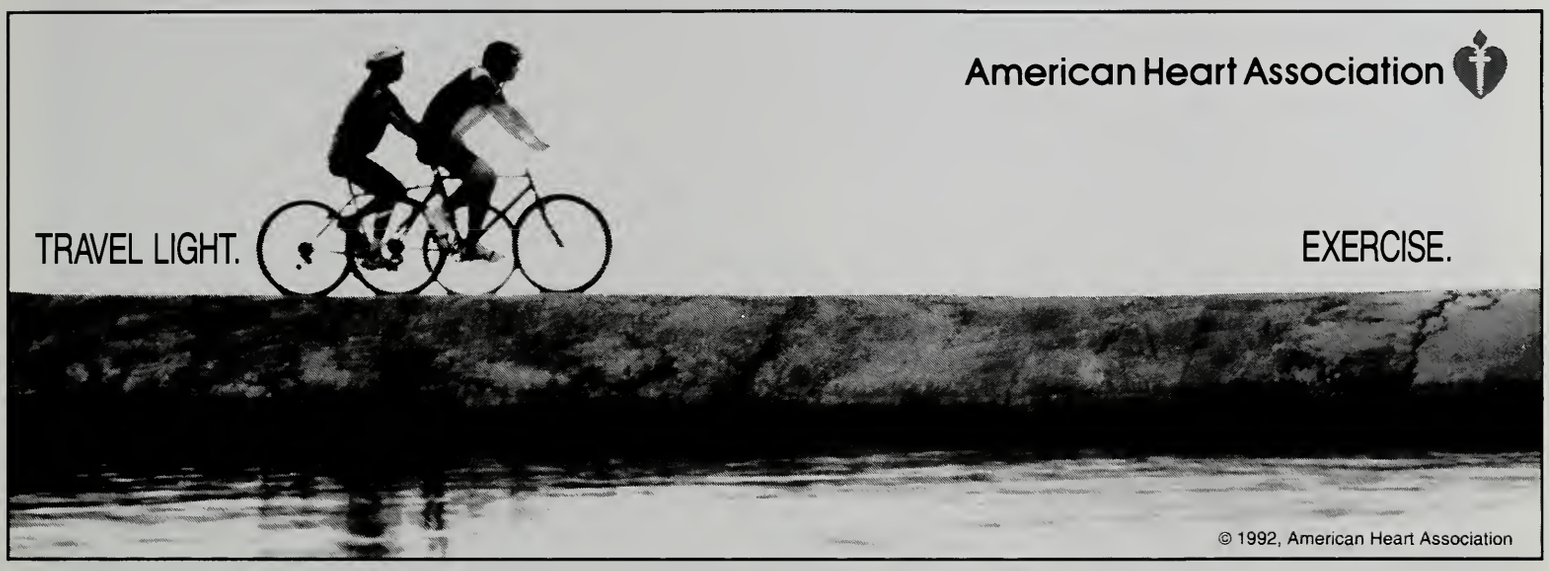

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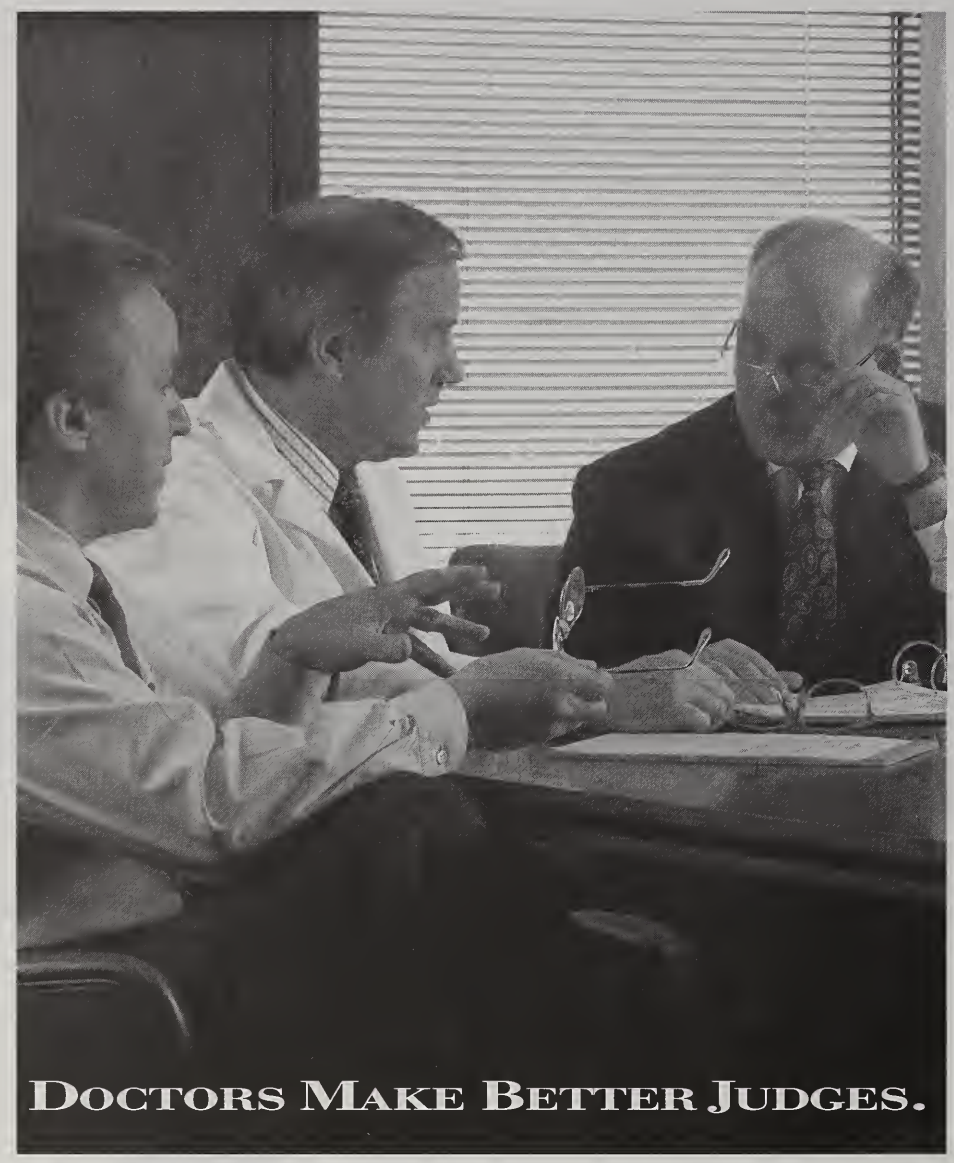

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"Being a doctor has allowed me to provide the best for my family."

DR. JANELLE GOETCHEUS, MEDICAL DIRECTOR, HEALTH CARE FOR THE HOMELESS PROJECT, INC., WASHINGTON, DC

Dr. Goetcheus says that raising her children in a health recovery facility for the homeless is one of the greatest gifts she has given them.

Her gifts to her patients are even greater. Caring for Washington's homeless for almost a decade, she despaired at seeing simple medical problems grow severe when patients lacked a clean, quiet place where they could heal. Her answer was to found Christ House, a live-in respite care facility for the homeless — and home to her family.

Today, this center is part of Washington's Health Care for the Homeless Project. As medical director of both, Dr. Goetcheus is serving in an even greater capacity, reviving health and hope in those she serves.

The **Sharing the Care** program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Health Care for the Homeless, in support of those who, like Dr. Goetcheus, are part of the cure.

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At Mid-Winter Conference

Noted author Dr. Timothy Quill among speakers for Third Session on caring for the chronically ill

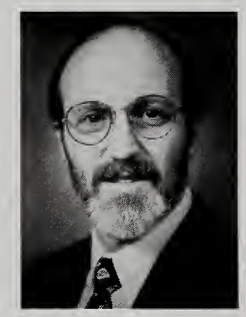
Timothy E. Quill, M.D., the author of *"Death with Dignity: Making Choices and Taking Charge"* will be one of the featured presenters for the Third Session at this year's WVSMA/WVACP Mid-Winter Seminars and Scientific Conferences, which will take place in Charleston from January 16-19 at the Holiday Inn - Charleston House.

"Dr. Quill is one of the strongest proponents of physician-assisted suicide in this country," Dr. Alvin Moss, a member of the Mid-Winter Clinical Conference Committee who is also a speaker for the Third Session stated. "He wrote the widely-quoted article on the case of Diane in the *New England Journal of Medicine* in 1991 and was one of three physician plaintiffs in the case decided by the Second Circuit Court declaring two New York statutes prohibiting physician-assisted suicide unconstitutional.

"Despite these actions, he opposes euthanasia and believes that physician-assisted suicide should only be used in the rare case in which other measures fail to provide the patient with comfort and an acceptable quality of life. He is one of the most provocative physicians in this country today," Dr. Moss added.

The title for the Third Session will be *"Caring for the Chronically Ill: New Challenges Resulting from Medicine's Successes,"* and it is scheduled to begin at 1:30 p.m. on Saturday, January 18. The first lecture for this session will be delivered by Jacqueline J. Glover, Ph.D., the associate director of the Center for Health Ethics and Law at the Robert C. Byrd Health Sciences Center of West Virginia University, and it is entitled *"What Patients Want and What They Fear."* After Dr. Glover's presentation, Dr. Quill will address participants about *"Responding to Patients' Requests for Physician-Assisted Suicide."*

Glover


Quill

Kelly

Moss

Following a break, this session will reconvene with a lecture by Patrick D. Kelly, Esq., of Steptoe & Johnson in Charleston on *"Honoring Patients' Wishes and Staying Out of Court."* Dr. Moss will then present the final topic for this session which will be *"Debunking Three Myths About the Care of the Dying They Taught Us in Medical School."*

Brief biographical sketches of these four speakers begins below and a registration form for this year's meeting appears on page 225. Phone the WVSMA at (304) 925-0342 for

Speakers highlighted

Dr. Glover received B.A. degree in philosophy and religion from the University of North Carolina in Wilmington in 1977. She then became a research assistant at the Kennedy Institute of Ethics at Georgetown University in Washington, D.C., and began working on her Ph.D. in philosophy with a concentration in bioethics.

In 1984, Dr. Glover relocated to Chicago to teach at the Loyola University Stritch School of Medicine as an instructor of medical humanities. Two years later, she returned to Georgetown University where she completed her doctorate and joined the faculty as an associate professor of health care sciences and as an associate professor of health care sciences. In addition to her teaching duties at Georgetown, Dr. Glover was director of the Program in Bioethics and served as a fellow in the Center for Health Policy.

This summer, Dr. Glover accepted her present role as an associate professor of medicine and pediatrics at the Robert C. Byrd Health Sciences Center of WVU in Morgantown, where she also serves as the associate director of the Center for Health Ethics and Law.

Dr. Quill received his undergraduate degree from Amherst College in 1971 and his M.D. from the University of Rochester in 1976. He completed his internal medicine residency in 1979 and a fellowship in med/psych liaison in 1981, both from the University of Rochester School of Medicine and Dentistry.

Currently, Dr. Quill is the associate chief of medicine at The Genessee Hospital, a professor of

medicine and psychiatry at the University of Rochester School of Medicine and Dentistry, and a primary care internist in Rochester, N.Y. He also directs the university's Program for Biopsychosocial Studies and its Fellowship in Advanced Biopsychosocial Studies.

Dr. Quill is a renowned author and lecturer on subjects concerning the doctor-patient relationship, including partnerships, communication barriers, delivering bad news and somatization. He focuses extensively on end-of-life decision making, and published the book *"Death and Dignity: Making Choices and Taking Charge"* in 1993 and two articles on this topic in the *New England Journal of Medicine.*

Mr. Kelly is a partner in the law firm of Steptoe and Johnson, where he concentrates his practice in the fields of health care law and governmental affairs.

Mr. Kelly has represented a variety of health care providers in certificate of need matters and hospitals regarding rate review issues before the West Virginia Health Care Cost Review Authority and the West Virginia State Tax Department. He routinely advises clients on matters relating to business organizations, business transactions, surrogate decision-making, the withdrawing of life-support systems, and guardianships. He also represents clients in administrative proceedings and in litigation issues.

A graduate of the West Virginia University College of Law, Mr. Kelly is a member of the West Virginia State Bar, the National Health Lawyers Association, the American Academy of Hospital Attorneys, and the West Virginia Guardianship Commission.

Dr. Moss is a practicing internist and nephrologist, who developed an interest in medical ethics as a result of his work in renal dialysis and transplantation. He is currently director of the Center for Health Ethics and Law at WVU, where he is also a professor of medicine and director of the Bioethics Program.

Dr. Moss has been a participant in the National Leadership Training Program for Physicians in Clinical Medical Ethics at the University of Chicago supported by the Pew Charitable Trusts and the Henry J. Kaiser Family Foundation. He serves as chairman of the Hospital Ethics Committee at WVU Hospitals and is the executive director of the West Virginia Network of Ethics Committees.

A member of the Guardianship Task Force of the West Virginia Department of Health and Human Resources, Dr. Moss chaired the committee that drafted the Health Care Surrogate Act of 1993 and the Do Not Resusitate Act. His research interests include the use of life-sustaining treatment, advance care planning, and narrative ethics.

Don't Miss Out!

Attend WVSMA/WVACP's Mid-Winter Seminars & Scientific Conferences

January 16-19
Holiday Inn - Charleston House
Charleston

See page 255 for Registration Form

MDTV to be featured again at Mid-Winter

Due to popular demand, the live demonstrations of MDTV which were presented at last year's WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences will again be offered in the Exhibit Hall at this year's meeting at the Holiday Inn - Charleston House.

The demonstrations will take place on Saturday, January 18 during the morning and afternoon breaks and at lunchtime. These presentations will be conducted by Dr. James Brick, medical director of MDTV, Dr. John Brick, co-director of MDTV, and Dr. Joe Skaggs, the medical staff consultant for the Charleston Area Medical Center.

MD TV™

Topics set for FP/Sports Medicine Conference

The Family Medicine Foundation of West Virginia will present its 10th Annual Family Practice Weekend and Sports Medicine Conference in Huntington at the Radisson Hotel from November 15-17.

This event is co-sponsored by the Marshall University School of Medicine's Department of Family and Community Health and Division of Sports Medicine. It has been reviewed and is acceptable for 18.75 prescribed hours by the AAFP, and AOA credit towards category 2-A for 18.75 hours are also approved.

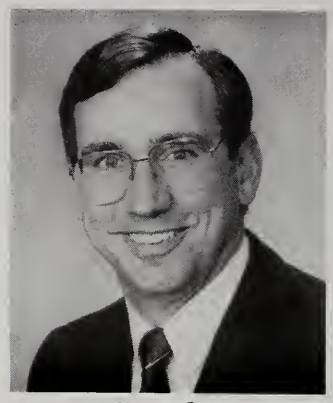
After registration and a continental breakfast, this year's meeting will officially kickoff on Friday, November 15 at 8 a.m. with welcomes by J. Wade Gilley, Ph.D., president of Marshall University, and Jose I. Ricard, vice president of the Family Medicine Foundation.

The first session will then feature topics about *"Medical Decisions in Recreational and Competitive Athletes."* The four presentations for this session will be *"Pre Season Cardiovascular Screenings,"* by Joe Czerkawski, M.D., of Jacksonville, Fla.; *"Closed Head Injuries: Evaluation and Management of Concussion,"* by Ross M. Patton, M.D., of Marshall University; *"Office-Based Fitness Testing,"* by William Marley, Ph.D., of Marshall University; and *"Fungal Infections in the Athlete,"* by Nancy Anderson, M.D. of Loma Linda University.

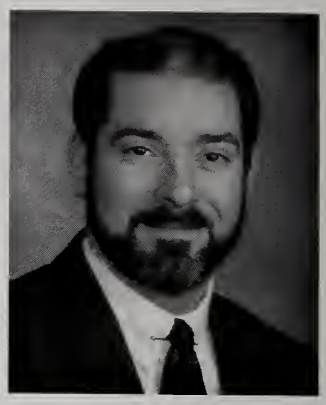
Following lunch, a special lecture entitled *"Catastrophic Neck Injury in Sports/Christopher Reeve Case Study"* will be presented by Dr. Scott Henson who served on the neurosurgery team for Christopher Reeve. A special video will then be shown which was created for attendees by Reeve who is bravely defying the odds and is determined to walk again after his tragic horseback-riding accident.

The following five lectures are also planned for the afternoon: *"On the Field Management of the Downed Athlete,"* by Janelle Thomas, M.S., A.T.C., of Huntington; *"Sports Medicine and the Law,"* by Herb Appenzeller, an attorney in Summerfield, N.C.; *"Pre Hospital Management of Severe Recreational Injuries,"* by Marvin Wayne, M.D., of Bellingham, Wash.; *"Noise and Hearing Loss in Sports,"* by Joseph Touma, M.D., of Huntington; and *"Case Studies in Pediatric Sports Injuries,"* by James Kyle, M.D., of Jackson General Hospital in Ripley.

Anderson



Spangler



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That evening, a Family Practice Club Meeting will take place at the Huntington Civic Center featuring A. Paul Holdren, president and CEO of PrimeOne, as the guest speaker. Following this meeting, a pregame party is planned in conjunction with the Huntington Blizzard hockey game to help raise funds for the Family Medicine Foundation of WV.

On Saturday, the first CME lecture will be given by David A. Baron, M.S., E.D., D.O., F.A.C.N., of Ambler, Pa., who will discuss *"Depression: The Clinical and Economic Outcomes."* The other lectures that morning will include *"The Co-Morbidity of Depression and Pain,"* by Stefan P. Kruszewski, M.D., of Pottsville, Pa.; *"Guidelines and Treatment of Allergic Rhinitis,"* by Dennis Spangler, M.D., of Atlanta; *"Risk Stratification and Management of Ischemic Heart Disease,"* by William Boden, M.D. of Boston; and *"Appropriate Use of Narcotics in Those Patients Without Malignancies,"* by Timothy Deer, M.D., of Charleston.

After lunch, the scientific sessions will feature John Murray, M.D., of Vanderbilt University discussing *"The Seen and Unseen Cause of Uticaria - Prevention and Treatment;"* Robert P. Rapp, Pharm.D., of the University of Kentucky talking about *"The Use, Misuse and Abuse of Antibiotic Therapies;"* Joann Blessing-Moore, M.D., of Stanford University Hospital speaking on *"A Step-Care Approach to the Treatment of Upper Respiratory Allergy;"* Rocco Morabito, M.D., focusing on *"Causes and Treatment of Enuresis;"* and Jeffrey Fawver, M.D., of Indianapolis presenting a lecture entitled *"Sometimes It's Hard to Be A Woman."*

Five presentations are planned for Sunday morning and then the meeting will conclude at 12:30 p.m. after the drawing for booth visitation door prizes. Sunday's presentations include *"Type II Diabetes: New Strategies for Improving Glycemic Control,"* by Gail Burchett, D.O., of Pueblo, Colo.; *"Managing Insomnia,"* by Karl Doghramji, M.D., of Philadelphia; *"Fibromyalgia vs. Arthritis,"* by Jill Vargo, M.D.; *"Male Testosterone Deficiencies,"* by Steven Winters, M.D., of Pittsburgh; and *"Managed Care Prescribing Risk Factors,"* by Ken Freeman, M.D., of Clinton, Md.

For more information about the conference, phone 776-1178.

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Dr. Earl Grollman to speak at annual Kanawha Hospice seminar at UC

Kanawha Hospice Care, Inc. is sponsoring *"Living with Loss; Healing with Hope: Fourth Annual Hospice and Palliative Care Conference"* with speaker Dr. Earl Grollman at the University of Charleston on November 21 from 8:45 a.m. - 3:30 p.m.

Dr. Grollman is a pioneer in the area of crisis intervention, and is a renowned author, rabbi, lecturer, and TV personality. He is a respected authority in the field of dying, death and bereavement, and has written 24 books, including *Talking About Death*, which received the international UNESCO Award.

This CME activity has been designated by the Charleston Area Medical Center for 5.5 hours in Category 1 credit for the Physician's Recognition Award of the AMA.

For more information, contact Kanawha Hospice at (304) 768-8523.

Financial assistance available for patients from Leukemia Society

The Leukemia Society of America's Patient Aid Program provides supplementary financial assistance to patients with leukemia, the lymphomas, multiple myeloma and Hodgkin's disease, as well as referral services to other sources of help in the community.

The Society's Patient Aid Program, supported by public contributions, is administered through the local Western Pennsylvania and WV Chapter. Monies can be used for medicines to treat leukemia and allied diseases, the processing, typing and screening of blood components, transportation to doctor's offices and some X-ray therapy.

For more details, contact the Leukemia Society of America at (800) 726-2873.

KidsPeace offering toll-free assistance

For the benefit of the professional community, KidsPeace, which is the nation's largest organization serving children and families in crisis, offers a variety of free services and direct links to national programs.

Call 1-800-KID-SAVE for KidPeace's National Referral Network.

Free government catalogue offers listing of medical resources

A collection of information resources for healthcare practitioners and biomedical researchers is available free in a new catalogue from the Superintendent of Documents.

Entitled *"Catalogue of Resources on Medicine, Biomedical Research and Mental Health,"* this publication presents more that 100 print and electronic products about diagnosis and pathology, biomedical research, clinical practice and preventive medicine, medical reimbursement, mental health and substance abuse, public health reports, etc.

Send requests to Superintendent of Documents, Stop SM, Washington, DC 20401, or fax requests to (202) 512-1656.

Snowshoe site for ACC conference

The American College of Cardiology is again offering its *"Cardiovascular Conference at Snowshoe"* from February 3-5 at Mountain Lodge Conference Center in Snowshoe, W.Va.

A total of 14 Category 1 credits are being offered for this CME event.

For more details, phone the ACC at (800) 253-4636.

Medical Meetings

November

1-3 - New Developments in the Pathogenesis & Treatment of NIDDM (sponsored by the American Diabetes Asssociation of Arizona and the National Institute of Diabetes and Digestive and Kidney Diseases), Scottsdale, Ariz.

2-6 - American Society for Reproductive Medicine, Boston

2-7 - American Cancer Society, Inc., Orlando, Fla.

8-13 - American College of Allergy, Asthma & Immunology, Boston

9-11 - American Society of Maxillofacial Surgeons, Dallas

13-15 - EPA Region III Eighth Annual Chemical Emergency Preparedness and Prevention Conference, Charleston

14-17 - Consultation-Liaison Psychiatry: Back to Basics (sponsored by The Academy of Psychomatic Medicine), San Antonio, Texas

15-19 - Gerontological Society of America, Washington, D.C.

20-24 - Southern Medical Association, Baltimore

27-29 - 6th Annual International MRI Orthopedic Workshop (sponsored by MRI Education Foundation, Inc.), Chicago

December

2-3 - On Electronic Patient Records (sponsored by Medical Records Institute), San Francisco

5-11 - American Epilepsy Society, San Francisco

8-11 - AMA Interim Meeting, Atlanta

January

6-15 - National Association of EMS Physicians, Naples, Fla.

16-19 - WVSMA/WVACP's Mid-Winter Seminars & Scientific Conferences, Charleston

CME Events

Charleston Area Medical Center - Charleston

October 18
"Pediatric Outreach Appreciation Day"

October 26
"Sixth Annual Vascular Surgery Conference Update on Cerebrovascular Disease"

November 7
"The Cost Effective Care of Managing the Patient with Valvular Heart Disease" (Teleconference)

November 21
"Non-Invasive Obstetrical Interventions" (Teleconference)

December 5
"Wound Classification and Management" (Teleconference)

Huntington Med. Comm. Foundation - Huntington

October 28
"Current Therapy for Prostate Carcinoma," Rocco A. Morabito, M.D., Logan General Hospital Staff Meeting, Logan, 6 p.m.

November 7
"Diabetes Update: What's Hot, What's Not," Bruce Chertow, M.D., Putnam General Hospital Staff Meeting, Hurricane, 6 p.m.

Marshall Univ. School of Medicine - Huntington

October 21
"Internal Medicine Review - Intensive Management of Hyperlipidemia," James W. Anderson, M.D., Kentucky - Huntington Internal Medicine Group,

Robert C. Byrd HSC of WVU - Morgantown

October 16-18
"WV Conference on Aging" - Canaan Valley Resort, Davis

October 18
"The 7th Annual Microbiology One-Day Workshop"

October 19
"The WV State Trauma Audit Review (STAR)" - Lakeview Resort and Conference Center, Morgantown

October 25
"Fall Cancer Conference"

October 25-26
"Musulosketal Radiology Update"

October 25-26
"Foot and Ankle Problems in the Athlete" - Erikson Alumni Center, Morgantown

October 29-30
"The Rural Health Conference" - Marriott Hotel, Charleston

November 1
"Second Annual Cost-Effective Evaluation and Management of Lower Back Pain"

November 2
"Pat Tuckwiller Memorial Lecture" - Lakeview Resort and Conference Center, Morgantown

November 8
"Acupuncture in Medical Practice"

November 8-10
"13th Annual Hypnosis Workshop"

November 15
"Mental Illness and Aging: Treatment, Ethics and Public

Area Outreach Programs

Sponsored by CAMC ◆ & Robert C. Byrd HSC of WVU ◆

Fairmont
- Fairmont General Hospital, November 5, 7:30 p.m. - "Acute Airway Management and Rapid Sequence Intubation," William Rose, M.D.

Logan
- Logan General Hospital, October 18 - "Facial Trauma," David Wise, M.D. and Lee Allen, M.D.

Parkersburg
- Camden Clark Hospital, October 22 - "Endocrinology," Robert Hoeldtke, M.D.

White Sulphur Springs
- The Greenbrier Clinic, October 28 - "Sports Medicine - Office Practice Pearls

Poetry Corner

To CC

The wind blows the dark cloud.
A pall wafting like effervescent eddies
Of smoke.

I'm watching now as you sleep.
Narcosis a compliment of pain relief and
unmetabolized ammonia.

We have talked and you know.
You knew before, but . . . it seemed
So distant.

Now its here, creeping . . no . . running.
Time so measured that it can be
Touched.

We really don't cure anything
Quoth an old book. The cure is
No treatment.

Walking outside I go to the hillside
To stand and watch the sunrise . . .
Listening, smelling.

Dew streams from new mown hay.
Pollinated bumblebees buzz me from
Their flowers.

Compassion, presence, dignity.
I do have a treatment plan . . a cure
For us both.

P. Van Swearingen, M.D.

Mickey Finn

Never give a Mickey Finn,
I learned in medical school -
nor now too a Kevorkian.

This needs taken in,
a posit for a golden rule -
never give a Mickey Finn.

Soak it up again,
never do anything cruel,
nor now too a Kevorkian.

No variant bin,
each case should point out to you -
never give a Mickey Finn.

These precepts we tend,
not to lose our cool,
nor now too a Kevorkian.

A message to send:
use these teaching tools -
never give a Mickey Finn,
nor now too a Kevorkian.

John Henry McWhorter, M.D.

This page of material is submitted and paid for by the Bureau for Public Health.

WIC sets guidelines for whole milk for children

There have been a number of questions raised recently regarding the use of whole milk for infants and children up to the age of two years.

To help clarify this subject, the West Virginia Women, Infants, and Children's Program (WIC) offers the following information for the use of whole milk in the WIC Program:

(1) The Committee on Nutrition of the American Academy of Pediatrics recommends the consumption of breast milk or iron-fortified formula, along with age-appropriate solid foods and juices, during the first 12 months of a child's life. The AAP recommends that whole cow's milk and low-iron formulas NOT be used during the first year of life. (AAP, The Use of Whole Cow's Milk in Infancy, *Pediatrics* 1992, 89; 1105-9). **Therefore, the WV WIC Program does not allow whole milk before the age of one.**

(2) Per recommendations of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents (National Cholesterol Education Program/NIH), the American Academy of Pediatrics Committee on Nutrition, and The American Heart Association Nutrition Committee, fat and cholesterol should not be restricted during the first two years of life. (AAP, *Pediatric Nutrition Handbook* 1993, page 44; NIH, *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*, 1991, page 1). **Therefore, the WIC food packages for children ages 12 to 23 months offer only whole milk.**

(3) Since most brands of lactose-reduced milk are not whole milk, the West Virginia WIC Program does not allow lactose-reduced milk until the age of two. However, infants and pediatric formulas are allowed if prescribed by a certified healthcare professional with prescriptive authority.

For more information about the WIC Program, call (304) 558-0030.

Mad Cow Disease Not Seen As Threat in U.S.

Mad Cow Disease or *Bovine Spongiform Encephalopathy* (BSE), is currently limited to the United Kingdom and a few countries which have imported cattle from the UK.

The U.S. has not imported any beef or cattle from the UK since 1989, and also has in place a surveillance program through the U.S. Department of Agriculture (USDA) to routinely sample cattle from 43 states, and to examine any cattle submitted for slaughter that demonstrate neurological disease. To date, over 2,700 samples have been examined and no cases of BSE have been identified.

BSE is caused by an organism smaller than a virus, often referred to as a *prion, or incomplete virus.* The diseases caused by these organisms were formerly called the family of *slow viruses.* Today, they are generally addressed as *transmissible spongiform encephalopathies* because of the very similiar pathological presentation, although the relationship of these diseases to one another are not clear.

These diseases are described as "spongiform" because specific areas of grey matter of the brain develop vacuolization, which, historically, appears like a sponge. These areas vary in the distribution and severity with the species involved. In the case of BSE, specific areas of the grey matter of the spinal cord are also involved. An abnormal protein is also deposited which differs pathologically and in anatomical location from that deposited in Alzheimer's disease.

There is no proven link or association between BSE and *human Creutzfeld-Jacob Disease (CJD).* There is no epidemiological or etiological evidence of any relationship between these two diseases. The furor in the UK is based upon an assumption that there is an unproven association between the disease of cows and the disease of man. Ten cases of an unusual variant to CJD occurred in young people in the UK. Those variants included the fact that 5 of the 8 patients who died of CJD since May 1995 were under the agge of 30. Four cases have been in tens. In the classical disease, over 99% of the victims are 35 years of age or older. Yet, based solely upon the fact that no other alternative could be found, a scientific board appointed by the British government made the presumed association with BSE. At this time, all evidence is strictly circumstantial.

In the U.S., 60 veterinary labs and 250 USDA and state veterinarians participate in the surveillance program to test for BSE in U.S. cattle. The U.S. Centers for Disease Control and Prevention launched a similiar surveillance program in the early 1990s by studying all recent cases of human CJD in Colorado, California, Minnesota and Oregon. At this time, there is no reason to consider any threat of CJD from the consumption of American grown beef. All indications are that the national cattle herd is currently free of BSE.

For more information, call Carl Berryman, D.V.M., M.P.H., of the Bureau's Division of Surveillance and Disease Control at (304) 558-5358.

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Robert C. Byrd Health Sciences Center of West Virginia University News

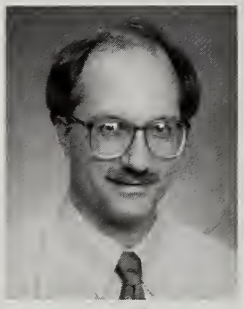
Compiled from material furnished by the Robert C. Byrd Health Sciences Center of WVU, Communications Division, Morgantown

Four new leaders join School of Medicine

Jacques

Johnstone

Halperin


Koch

The WVU School of Medicine has named the following new faculty members at its Morgantown campus: Dr. C. H. Mitch Jacques as the chair of the Department of Family Medicine; Dr. Robert E. Johnstone as chair of the Department of Anesthesiology; Dr. Alan K. Halperin as chief of internal medicine; and Dr. Timothy R. Koch as chief of gastroenterology.

Since 1993, Dr. Jacques has chaired the Department of Family Medicine at WVU's Charleston Division. A graduate of the College of Human Medicine at Michigan State University, Dr. Jacques earned a Ph.D. in chemical engineering at North Carolina State University, and worked as a senior research engineer for General Motors in Michigan before entering medical school.

Dr. Jacques has been involved with the training of physicians in primary care since his residency at Pennsylvania State University, Hershey, in 1984. He was associate director of residency education at the University of Pennsylvania's Williamsport family medicine program from 1984-88; on the faculty at Hershey from 1988-90; and residency director and associate chair for academic affairs in family medicine at Texas Tech University, Lubbock, from 1990-92.

Dr. Jacques takes the place of Dr. Glen Aukerman, who resigned in 1995. Dr. Anne Cutlip has been serving as interim chair.

Dr. Johnstone, who served as interim chair of the Department of Anesthesiology since 1995, came to WVU in 1991. He served as acting chair of the department in 1994 and vice chair in 1993. He was director of resident education from 1991-1993.

Dr. Johnstone received his medical degree from OSU. He served a medical internship at the University of Cincinnati and completed a residency at the University of Pennsylvania. He completed an M.B.A. at Troy State University, Dothan, Ala.

Dr. Johnstone has worked in private practice, as well as academics. He has served as medical director of schools of nurse anesthesia and respiratory therapy.

Dr. Johnstone, a lieutenant colonel in the U.S. Army Reserve Corps, is on University Health Associates' board of directors. He is on the American Society of Anesthesiologists' Committee on Quality Improvement and Practice Management, and chairs the society's Committee on Value-based Anesthesia Care.

Dr. Johnstone replaces the late Edward H. Stullken, Jr., M.D.

Dr. Halperin received his M.D. at the University of Kansas and served a residency at the University of Wisconsin. He is board certified in internal medicine.

Dr. Koch is board certified in gastroenterology and internal medicine. He earned his M.D. degree at the University of Chicago and served a residency at the Mayo Clinic.

Clinic treats patients with lung cancer

WVU's Multidisciplinary Lung Cancer Clinic, which is a part of the Mary Babb Randolph Cancer Center, is providing comprehensive consultative services and expedited invasive and non-invasive procedures for the diagnosis and treatment of lung cancer.

Specialists from pulmonary medicine, cardiothoracic surgery, medical oncology, radiation oncology and diagnostic radiology are involved with the clinic, which is directed by Dr. David Weissman, pulmonary medicine, and Dr. Geoffrey Graeber, cardiothoracic surgery. Patients can be referred at any stage of their disease.

For more information or to refer a patient, phone 1-800-WVA-MARS.

MPH program now open to non-physicians

WVU's graduate program in public health — previously open only to medical residents — has been expanded to serve people in all the health care professions.

The Master of Public Health degree (MPH) is being offered through the School of Medicine's Department of Community Medicine. Students in the program study health policy, epidemiology, environmental health sciences, biostatistics and health services administration.

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Marshall University School of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Marshall welcomes future doctors in first "White Coat Ceremony"

Before being "cloaked" by Dean Dr. Charles McKown, medical students heard from Dr. Henry Taylor, commissioner of the West Virginia Bureau for Public Health, that although the traditional white coat can be many things, it ultimately is a mantle of responsibility and hope.

The School of Medicine ushered in the Class of 2000 with West Virginia's first White Coat Ceremony, an event designed to remind students that compassion goes hand-in-hand with technical excellence.

During the event, students were "cloaked" with the white coats that symbolize their profession and took an oath patterned after the Hippocratic oath. Dr. Henry Taylor, commissioner of the West Virginia Bureau for Public Health, was the featured speaker.

The White Coat Ceremony was funded by the Arnold P. Gold Foundation, which supports innovative programs and projects that foster humanism in medicine. Founders Arnold and Sandra Gold say they want to make certain tomorrow's doctors know how to care as well as cure.

The ceremony was part of the School of Medicine's opening exercises, which included award presentations to faculty and students.

Students presented awards to: Dr. Mahmood Heydarian, Pediatrics; Dr. Robert Carlson, Surgery; Dr. Gary Rankin, Pharmacology; Dr. Sasha Zill, Anatomy; Dr. Mitchell Berk, Anatomy; Dr. Maurice Mufson, Medicine, and Dr. Patricia Kelly, Pediatrics. "Outstanding Department" honors went to Family and Community Health, Anatomy, and Pharmacology.

The following 8 students received awards for achieving perfect 4.0 grade point averages last year: G. B. Corn, Adam Franks, Gregory Larsen and David Majdalany, all of Huntington; Devin King of Independence; Amy Curdie of Morgantown; Bryan Springer of Stevensville, Md., and Terry Justice of Ashland, Ky.

Fourth-year medical student Sara Samosky of Huntington received the inaugural Mildred Mitchell-Bateman Award, and third-year student Joshua Haddox of Huntington received the Glenn Hunter Award for pathology.

Students newly selected for induction into the medical honorary Alpha Omega Alpha were: Danielle King and Sara Samosky of Huntington, Charles Clements II of Scott Depot, and Teresa Duncan of Gallipolis Ferry.

State physicians host med students

Physicians across West Virginia hosted Marshall medical students for two weeks in July as part of the school's Transition to Primary Care course, which gives students a strong exposure to ambulatory care before starting their third year of medical training.

Participating West Virginia physicians, by county, were:

Boone - Dr. Ron Stollings
Braxton - Dr. William Given
Cabell - Drs. David Ayers, James Becker, Dennis Briley, Lisa Burk, Brent Burket, Henry Driscoll, Lynne Goebel, Hyla Harvey, Helen How, Paul Little, Mike Meadows, Kathleen O'Hanlon, Linda Savory, Timothy Saxe, Mitch Shaver, William Skeens, and Hina Trivedi
Grant - Drs. Jerry Hahn and Fernando Indacochea
Greenbrier - Dr. Nathaniel Harris
Jackson - Dr. Cindy Reese
Kanawha - Drs. Robert Hively, James Mears, Norman Montalto, Mark Newbrough
Logan - Dr. D.H. Donohoe
Mason - Drs. Michael McGinnis and Minerva Ramirez
McDowell - Dr. David Carr
Monongalia - Dr. Frederick Blum
Putnam - Dr. Kevin Conaway
Wayne - Drs. Joe Shy and Stephen Shy
Wood - Drs. John Beane and Richard Cain

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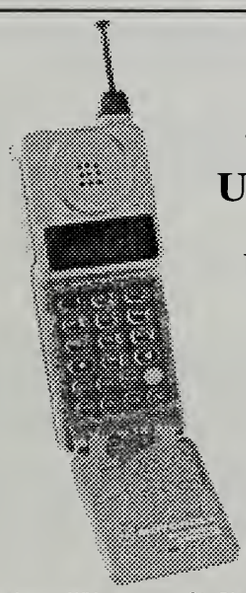

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Plan now to make a difference this year

Greetings from the West Virginia State Medical Association Alliance. As the 1996-97 president, I want to introduce you to the Alliance's health project for the coming year.

SAVE-A-Shelter was recently introduced by the American Medical Association Alliance in conjunction with the AMA. The goal of this nationwide initiative is to have medical societies and alliances adopt an abuse shelter, transition home or rape crisis center. Together, physicians and their spouses have the potential to help thousands of victims of abuse, to strengthen support services, and to enable physicians to more comfortably refer women for assistance and treatment.

What your component medical society and alliance can do:

1. Plan a meeting with county alliance and medical society leaders and review the services in your area available to victims of abuse. Consider what your organizations can realistically offer in terms of volunteer time, awareness, funds, health-related publications, etc.
2. Contact the shelter. Ask them their needs and request a "wish list." Discuss your plans with the shelter.
3. Kick off your SAVE-A-Shelter campaign with media announcement, press conference, or other event.

Ideas for SAVE-A-Shelter

November

- Announce a yearlong fund-raising effort for the shelter, and be creative with funding initiatives. If the shelter needs beds and dressers, for example, your effort could center around the "Furniture Fund."
- Ask for the shelter's assistance in planning an educational forum to let physicians and the public know what services are available. Or, host a workshop for physicians at the shelter and utilize the AMA's Diagnostic and Treatment Guidelines on domestic, child, or elder abuse; sexual assault; family violence and media violence. Call the AMA Department of Mental Health at (312) 464-5066 for more information.

December *(Safe Toys Month)*

- Organize a Holiday Drive for needed items. These could include winter clothes, personal items or other items on the shelter's wish list.
- Have a class of high school students decorate a tree for the shelter.

January/February

- Host a book reading for children and donate used (non-violent) books.
- Donate "Hands Are NOT for Hitting," an activity aimed at very young children.
- Design a scholarship program to assist women who want to attend school.
- Plan a tutoring program for school-age children.

March/April *(April is National Child Abuse Prevention Month)*

- Coordinate fund drives or shelter showers during spring meetings to allow all members to contribute.
- Donate "I Can Choose" to children in the shelter or home.
- April 21-27 is National Immunization Week. Hold a childhood immunization education program for mothers at the shelter.

I hope that you find SAVE-A-Shelter to be a very rewarding and challenging endeavor.

Amy Ricard
WVSMAA President

Med Student Section News

Let's keep up the good work!

Dear Fellow Med Students:

Hello! Hope all of you are having a great year. The WVSMA-MSS has been quite busy since my last letter and I just wanted to take a minute to bring all of you up-to-date.

First, I would like to announce the WVSMA-MSS component society officers:

	Marshall	**WVU-Charleston**	**WVU-Morgantown**	**WVSOM**
President	Jason Harrah	Amy Shamblin Horsman	John S. Haid	Norman Wood
VP	Lora Cremeans	Jennifer Mills	Victor Starcher	
Secretary	Nicole Lackey	Johnsey Leef (Sec./Treasurer)	Christy Shaffer Canody (Sec./Treasurer)	
Treasurer	Adam Frank			

Congratulations to all of you and I look forward to working with you this year. Please feel free to contact any of these officers or the Executive Council officers at anytime. Your ideas are always welcome.

This past June, several members of the WVSMA-MSS attended the AMA Annual Meeting in Chicago. This was not only a wonderful learning experience, but also lots of fun. We met many interesting people, debated important topics and voted on many resolutions such as those concerning tobacco consumption by minors, domestic violence screenings, and AMA-MSS communications. On behalf of all those who attended, I would like to thank those of you that made our attendance possible.

In August, we had our second WVSMA-MSS Executive Council Meeting. During this time, we discussed our plans for a recruitment video which will be aimed at potential new members with the goal of defining the WVSMA structure and function, as well as showing them the many benefits of membership - - what the WVSMA-MSS can do for them. I want to thank Donna Webb and the WVSMA for all their help in organizing the video.

At the meeting, we also outlined a proposal for a statewide blood drive which would be sponsored by WVSMA-MSS in conjunction with the American Red Cross. This event is tenatively scheduled for February 26 and more information will be forthcoming as plans are finalized. In addition, we also discussed our schedule for our annual meeting which will take place at the Charleston House - Holiday Inn on January 18 in conjunction with the WVSMA's Mid-Winter Clinical Conference. This event promises to be fun and informative so please plan on attending. Further details will be published in upcoming issues of the *Journal*.

In closing, I would like to congratulate all the component societies for an outstanding job. Keep up the good work, especially the community service. I would like to again encourage all of you to attend our next Executive Council meeting, which will take place at the WVSMA office on November 9 at noon, our annual meeting in January, as well as the AMA Interim Meeting in Atlanta in December. I'm looking forward to seeing you there.

Melissa Matulis, MSIV
WVSMA-MSS President

New Members

We are pleased to welcome the following new members to the WVSMA:

Rajiv Khanna, MD
Beckley, WV

Gyanesh Agrawal, MD
Chesapeake, WV

Robert W. Rice, MD
Beckley, WV

James W. Freese, MD
Wheeling, WV

Sam G. Starcher, DO
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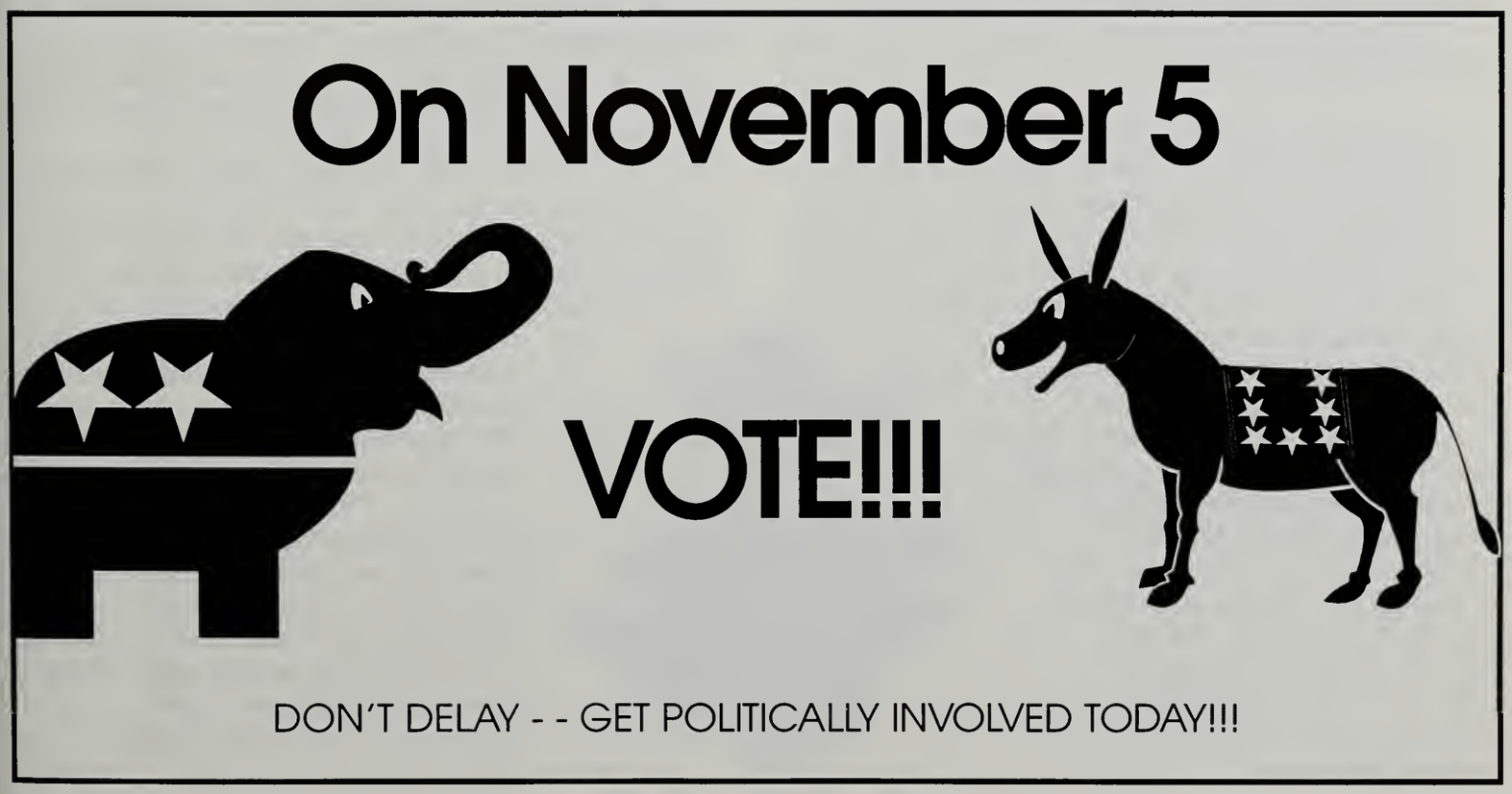


Obituaries

Miroslav Kovacevich, M.D.

Dr. Miroslav Kovacevich, 81, formerly of Charleston, died June 24 in Mt. Dora, Fla., after an extended illness.

During his career, Dr. Kovacevich had practiced general medicine and psychiatry for 50 years. He and his wife, Vera, along with their youngest son, Robert, had immigrated to the United States in 1949 from their home in Belgrade, Yugoslavia. They resided in Charleston until 1962 when the family moved to Boston after Dr. Kovacevich received an appointment from Harvard Medical School to study psychiatry. Four years later, he returned to Charleston where he practiced until 1990. In 1992, the Kovacheviches moved to Florida to be near their sons, Robert and Phillip and their grandchildren.

In addition to being a member of the WVSMA, Dr. Kovacevich was an active member of the American Psychiatric Association, the Kanawha Medical Society, and had been an assistant clinical professor at the West Virginia University School of Medicine for over 10 years.

Dr. Kovacevich loved music and the arts, and was himself a talented pianist and painter. He and Vera were active supporters of the West Virginina Symphony Orchestra and the Sunrise Museum.

Dr. Kovacevich is survived by wife, Vera; sons, Robert and Phillip of Orlando, Fla., and Michael of Wareham, Mass.; daughter, Miriana Moss of Atlanta; and seven grandchildren.

Donations can be made to the West Virginia Symphony Orchestra and Kanawha United Presbyterian Church.

David A. Haught, M.D.

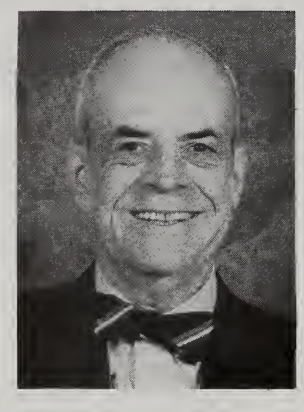
Dr. David A. Haught, 76, of Ocala, Fla., formerly of Huntington, died July 3 in Munroe Regional Medical Center. He was a retired anesthesiologist.

Dr. Haught was born in Cattlesburg, Ky., and received a B.S. degree in pharmacy from West Virginia University and then obtained his medical degree from the Medical College of Virginia in Richmond. After he interned at St. Mary's Hospital, he began practicing in Huntington in 1948.

Dr. Haught served in the U.S. Navy from 1950-1952. In addition to being a WVSMA member, Dr. Haught belonged to the Cabell County Medical Society.

Survivors include two sons, David M. Haught of Huntington and Steven E. Haught of Dunbar; a daughter, Nadine C. Baker of Tampa, Fla.; a stepson, Stephen Pyles, M.D., of Ocala, Fla.; and a stepdaughter, Sue Ross of Tallahassee.

D. Verne McConnell, M.D.



Dr. D. Verne McConnell, founder of Plastic Surgery, Inc. and a specialist in plastic and reconstructive surgery in Wheeling since 1973, died July 22 at his Wheeling home. He was 64 and the cause of death was cancer.

Born in Cleveland and brought up in Knoxville and Toronto, Ohio, Dr. McConnell graduated from Toronto High School and the Mercersburg Academy in Pennsylvania and from Princeton University in New Jersey in 1955. He graduated from Columbia University's College of Physicians and Surgeons in New York in 1959 and did his training in surgery at The Johns Hopkins Hospital in Baltimore; Vanderbilt University in Nashville; and the University of California at Los Angeles Center for the Health Sciences.

Dr. McConnell practiced plastic and reconstructive surgery in Los Angeles and taught at U.C.L.A. from 1966-73, when he returned to the Ohio Valley to open his own practice. He was also a clinical professor of plastic and reconstructive surgery at the West Virginia University School of Medicine in Morgantown. He was on the staff of Wheeling Hospital and the Ohio Valley Medical Center in Wheeling; Ohio Valley Hospital and St. John Medical Center in Steubenville; and Weirton Medical Center.

A former president of the West Virginia Chapter of the American College of Physicians and Surgeons and of the Ohio Valley Society of Plastic and Reconstructive Surgeons, Dr. McConnell made two trips to Ecuador to do plastic and reconstructive surgery with the non-profit plastic surgery team called Interplast. He also provided volunteer care one summer at the Indian Services Hospital in Gallup, N.M.

Dr. McConnell is survived by his wife, the former Jane Walker; two sons, Matthew of Worthington, Ohio, and William of Pittsburgh; two daughters, Sarah Hansen of Rahway, N.J., and Kathleen of Raleigh, N.C., and six grandchildren. He was preceded in death by his father, Donald W. McConnell, and his mother, Mabel Culp McConnell of Toronto.

Donations may be made to the Toronto High School Alumni Association, Verne McConnell Memorial.

Teofilo Jose Rojas Jr., M.D.

Dr. Teofilo Jose Benjamin Rosal Rojas Jr., 62, of Beckley died of natural causes on May 29 in an Atlanta hospital.

Born January 19, 1934 in Vigan, Ilocosur, Philippines, Dr. Rojas was the son of the last Dr. Teofilo and Rosario Rosal Rojas Sr. He graduated from the University of Santo Tomas, Manila, Philippines in 1959 and during his medical career in the Philippines he was chief of the Anesthesia Department at Cotabato Hospital and was a fellow of the Philippines College of Anesthesia.

In 1974, Dr. Rojas came to Beckley as an ER physician at Beckley Hospital and he also worked at Doctors Clinic in Beckley for one year. He established his solo practice in 1977 and retired on August 16, 1993, but worked part time at Quick Care Clinic in Parkersburg until his death.

While he practiced in Beckley, Dr. Rojas was medical director of Heartland Nursing Home for many years. In addition to being a WVSMA member, Dr. Rojas was a fellow of the American Academy of Family Physicians and a member of the Raleigh County Medical Society.

A member of St. Francis de Sales Catholic Church in Beckley, Dr. Rojas was a violinist there with the Knights of Columbus, 4th Degree. He was a member of the Serra Club of Beckley and a member of the Tuesday Night Men's Bowling League.

Survivors include his wife, Teresita Deocales Rojas of Beckley; two daughters, Theresa Rojas and her husband, Terence Whitt, Jennifer Bernadette and her husband, Alan Whitt, all of Atlanta; grandchildren, Benjamin, Alexander and Kirsten Marie Whitt, all of Atlanta; two sisters, Dr. Erlinda Rojas Santos and Vincenta R. Maceranas, both of Denver; and a brother, Cornelio Rojas of Quezon City, Philippines.

Donations of sympathy may be made to St. Francis de Sales Church Choir For Music and Instruments, 614 South Oakwood Ave., Beckley 25801.

John J. Schaefer Jr., M.D.

Dr. John J. Schaefer Jr., 70, one of the state's pioneers in open heart surgery, died March 20 at the home of his daughter, Debbie Schaefer, of South Charleston.

Dr. Schaefer was born in Yonkers, N.Y., and graduated from the New York Medical College in 1948. He interned and did his residency in general and thoracic surgery at Fordham Hospital in New York, and served for two years in the Army Medical Corps during the Korean War.

In 1960, Dr. Schaefer relocated to Charleston, where he practiced 28 years as a cardiovascular-thoracic surgeon. During his career, he also served as a clinical associate professor of surgery for the West Virginia University School of Medicine.

"He was very compassionate and hard-working," said Dr. Steven Artz, director of nuclear medicine at Charleston Area Medical Center's General Division.

After leaving Charleston, Dr. Schaefer practiced at the U.S. Naval Hospital at Cherry Point Marine Air Station, N.C., as well as at other hospitals in that area before retiring in 1992.

In addition to being a past member of the WVSMA, Dr. Schaefer was also a past member of the AMA, the Kanawha Medical Society and the Southern Medical Association. He was a founding member of the Society of Thoracic Surgeons.

Dr. Schaefer was a past member of Sacred Heart Co-Cathedral in Charleston and Annunciation Catholic Parish in Havelock, N.C.

Also surviving are his wife, Marie Goehler Schaefer; daughters, Mary Ellen Pauley of South Charleston, Karen Connell of Naperville, Ill., Susan Browing of Annville, Pa.; son, Dr. John J. Schaefer III of Pittsburgh, Pa.; sister, Julia Gilligan of Larchmont, N.Y.; brother, Thomas Schaefer of Waterford, Conn.; 12 grandchildren; several nieces and nephews.

Gates J. Wayburn Sr., M.D.

Gates J. Wayburn Sr., M.D., 84, of Destin, Fla., formerly of Huntington, died June 12.

Dr. Wayburn was a graduate of Emory University and Emory University Medical School. He interned at City Hospital in New York and later served in the 48th Surgical Hospital during WWII, participating in the invasion of North Africa through the Tunisian Campaign.

In 1944 after returning from his military service, Dr. Wayburn took specialty training for two years at the Obstetrics and Gynecological Center of Johns Hopkins Hospital in Baltimore. Dr. Hopkins then came to Huntington to complete his residency at St. Mary's Hospital. He practiced in Huntington for 35 years, where he was a member of the Fifth Avenue Baptist Church. He had been residing in Destin for the last nine years.

A WVSMA member since 1947, Dr. Wayburn was also a member of the AMA, the Southern Medical Association, and was a past president of the West Virginia Obstetrical and Gynecological Society. He was a life member of the American College of Surgeons and the International College of Surgeons, and a founding fellow of the American Fertility Society. For the past 49 years, Dr. Wayburn had been a member of Rotary Club International.

Survivors include his wife, Frances Thames Wayburn of Destin; a son and daughter-in-law, Gates J. Wayburn Jr., M.D. and Martha Wayburn of Nashville; and a niece, Lynn Shoenig of Atlanta.

Annual Audit 1995

The annual audit of the West Virginia State Medical Association for the calendar year 1995 has been completed by Ernst & Young LLP of Charleston. The complete audited financial statements including the report of independent auditors is as follows:

REPORT OF INDEPENDENT AUDITORS
To the Council
West Virginia State Medical Association

We have audited the accompanying statement of financial position of West Virginia State Medical Association (WVSMA) as of December 31, 1995 and the related statement of activities and cash flows for the year then ended. These financial statements are the responsibility of WVSMA's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of WVSMA as of December 31, 1995, and the changes in its net assets and its cash flows for the year then ended in conformity with generally accepted accounting principles.

As discussed in Note 1 to the accompanying financial statements, during 1995, WVSMA changed its accounting policies related to financial statement display and accounting for certain investments.

Ernst & Young LLP

May 15, 1996

BALANCE SHEETS—WVSMA

Assets	
Cash and cash equivalents—Note 4	$ 924,350
Accounts receivable, less allowance for doubtful accounts of $11,000	13,983
Other assets	16,762
Land, building, and equipment, net—Note 2	593,711
Long-term investments—Note 1	18,400
Total assets	$1,567,206
Liabilities and net assets	
Liabilities:	
Dues collected in advance	$ 678,004
Accounts payable	2,163
Accrued expenses and other liabilities	38,269
Note payable to bank—Note 4	408,355
Total liabilities	1,126,791
Net assets	
Unrestricted—Note 1	423,857
Temporarily restricted—Note 1	12,308
Permanently restricted—Note 1	4,250
Total net assets	440,415
Total liabilities and net assets	$1,567,206

See notes to financial statements.

Statement of Activities
Year ended December 31, 1995

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenues and other support				
Dues	$ 740,475	$ –	$ –	$ 740,475
Royalty endorsements	174,610	–	–	174,610
Advertising	28,043	–	–	28,043
Conferences and meetings	91,262	–	–	91,262
Investment income	23,723	1,552	–	25,275
Other income	17,760	–	–	17,760
Unrealized net gain on investments	–	14,150	–	14,150
	1,075,873	15,702	–	1,091,575
Net assets released from restrictions	3,394	(3,394)	–	–
Total revenues and reclassifications	1,079,267	12,308	–	1,091,575
Expenses				
Membership services	205,256	–	–	205,256
Conferences and meetings	278,231	–	–	278,231
Legislative	114,857	–	–	114,857
The West Virginia Medical Journal	133,981	–	–	133,981
Management and general	266,231	–	–	266,231
Professional liability	46,495	–	–	46,495
Total expenses	1,045,051	–	–	1,045,051
Change in net assets	34,216	12,308	–	46,524
Net assets at beginning of year	389,641	–	4,250	393,891
Net assets at end of year	$ 423,857	$12,308	$4,250	$ 440,415

See notes to financial statements.

Statement of Cash Flows
Year Ended December 31, 1995

Operating activities	
Change in net assets	$ 46,524
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Unrealized net gain on investments	(14,150)
Depreciation	25,317
Changes in operating assets and liabilities:	
Decrease in accounts receivable	17,611
Decrease in other assets	4,492
Decrease in dues collected in advance	(18,701)
Decrease in accounts payable	(18,198)
Decrease in accrued expenses and other liabilities	(6,701)
Net cash provided by operating activities	36,194
Investing activities	
Purchases of equipment	(15,799)
Net cash used in investing activities	(15,799)
Financing activities	
Repayment of note payable to bank	(43,980)
Net cash used in financing activities	(43,980)
Decrease in cash and cash equivalents	(23,585)
Cash and cash equivalents at beginning of year	947,935
Cash and cash equivalents at end of year	$924,350

See notes to financial statements.

1. Description of Organization and Accounting Policies

WVSMA is a nonprofit corporation organized under the laws of the State of West Virginia and exempt from income tax under Section 501(c)(6) of the Internal Revenue Code. WVSMA functions primarily to inform its members about proposed legislation, current professional developments, professional risk and malpractice liabilities. WVSMA also publishes the *West Virginia Medical Journal*. Substantially all of WVSMA's revenues are generated by dues assessments on its members and royalty endorsements.

Basis of Presentation

During 1995, WVSMA adopted Statement of Financial Accounting Standards (SFAS) No. 116, *Accounting for Contributions Received and Contributions Made*, SFAS No. 117, *Financial Statements of Not-for-Profit Organizations*, and SFAS No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations*. SFAS No. 116 establishes standards of accounting for contributions and requires that unconditional promises to give be recognized as revenue in the period received at their fair value. SFAS No. 117 requires that resources be classified for reporting purposes into three net asset categories as temporarily restricted, permanently restricted and unrestricted net assets according to the existence or absence of donor-imposed restrictions. Temporarily restricted net assets are those whose use has been limited by donors to a specific purpose or time period. Donor restricted contributions whose restrictions are met in the same reporting period are reported as unrestricted support. Permanently restricted net assets are those for which donors require the principal of the gift to be maintained in perpetuity. SFAS No. 124 requires not-for-profit organizations to record their investments in all debt securities and certain equity securities at fair value, with gains and losses (realized and unrealized) being recorded in the statement of activities and changes in net assets. Beginning net assets as of January 1, 1995, were restated to conform to the provisions of SFAS No. 116, SFAS No. 117 and SFAS No. 124. The cumulative effect of adopting these new standards was not material.

Use of Estimates

The preparation of the financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known which could impact the amount reported and disclosed herein.

Cash and Cash Equivalents

Cash and cash equivalents are comprised of short-term certificates of deposit and money market accounts recorded at cost, which approximates market. Bank balances as of December 31, 1995, approximated $991,000, of which approximately $115,000 was covered by federal depository insurance. The remaining balance is unsecured.

Allowance for Doubtful Accounts

WVSMA values its accounts receivable at net realizable value by expensing amounts determined to be uncollectible in the period of determination.

Land, Building, and Equipment

Land, building, and equipment are recorded at historical cost. Depreciation is computed by the straight-line method using estimated useful lives ranging from 5 to 35 years. The cost of maintenance and repairs is charged to income as incurred, and significant improvements are capitalized.

Recognition of Revenue

Members are billed in advance for the subsequent year's dues, which are treated as exchange transactions and earned ratably over the period to which they relate. All subsequent years' dues received prior to January 1 are reported as dues collected in advance.

Long-Term Investments

Long-term investments consist of equity investments in a permanently restricted endowment fund, which was established to utilize the dividend income to pay for the guest speaker at the annual meeting. These securities are recorded at fair value, based on quoted market prices.

Temporarily Restricted Net Assets

Dividend income and realized gains on the endowment fund equity securities restricted for the costs of the guest speaker at the annual meeting are reported as temporarily restricted revenue when received. When the donor restriction expires, that is, when the stipulated purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions.

Permanently Restricted Net Assets

These net assets consist of donor restricted funds of which the corpus is to be held in perpetuity. These funds consist of the equity securities in an endowment fund.

2. Land, Building, and Equipment

A summary of land, building, and equipment, and the related allowance for depreciation as of December 31, 1995, is as follows:

Land	$ 141,247
Building and improvements	635,585
Furniture and equipment	252,418
	1,029,250
Less allowance for depreciation	(435,539)
	$ 593,711

3. Future Minimum Rentals Under Operating Leases

WVSMA leases office and computer equipment under noncancellable operating leases with terms of one year or more. The following is a schedule by years of minimum future rentals for the years ending December 31:

1996	$21,494
1997	14,019
1998	11,683
Total minimum future rentals	$47,196

Total minimum future rentals do not include contingent rentals which may be assessed under the office equipment lease on the basis of usage in excess of stipulated minimums.

Rental expense in 1995 approximated $40,500, including $4,690 of contingent rental expense.

4. Note Payable to Bank

Terms of the agreement underlying the note payable to bank provide for interest at 1% above the annual percentage yield of certificates of deposit and other balances, if any, securing the loan. The note is repayable in 60 monthly installments of $5,200 (including principal and interest) followed by a balloon payment or refinancing of the then outstanding loan balance. The loan is primarily secured by a first deed of trust on the building which has a net book value approximating $416,000 at December 31, 1995. In addition, the loan is collateralized by a $300,000 certificate of deposit and money market account with a balance approximating $656,000 at December 31, 1995.

Interest paid approximated $24,000 in 1995.

Scheduled principal payments on the note payable in each of the next three years ending December 31 are as follows:

1996	$ 43,636
1997	45,777
1998	318,942
	$408,355

5. Royalty Endorsements

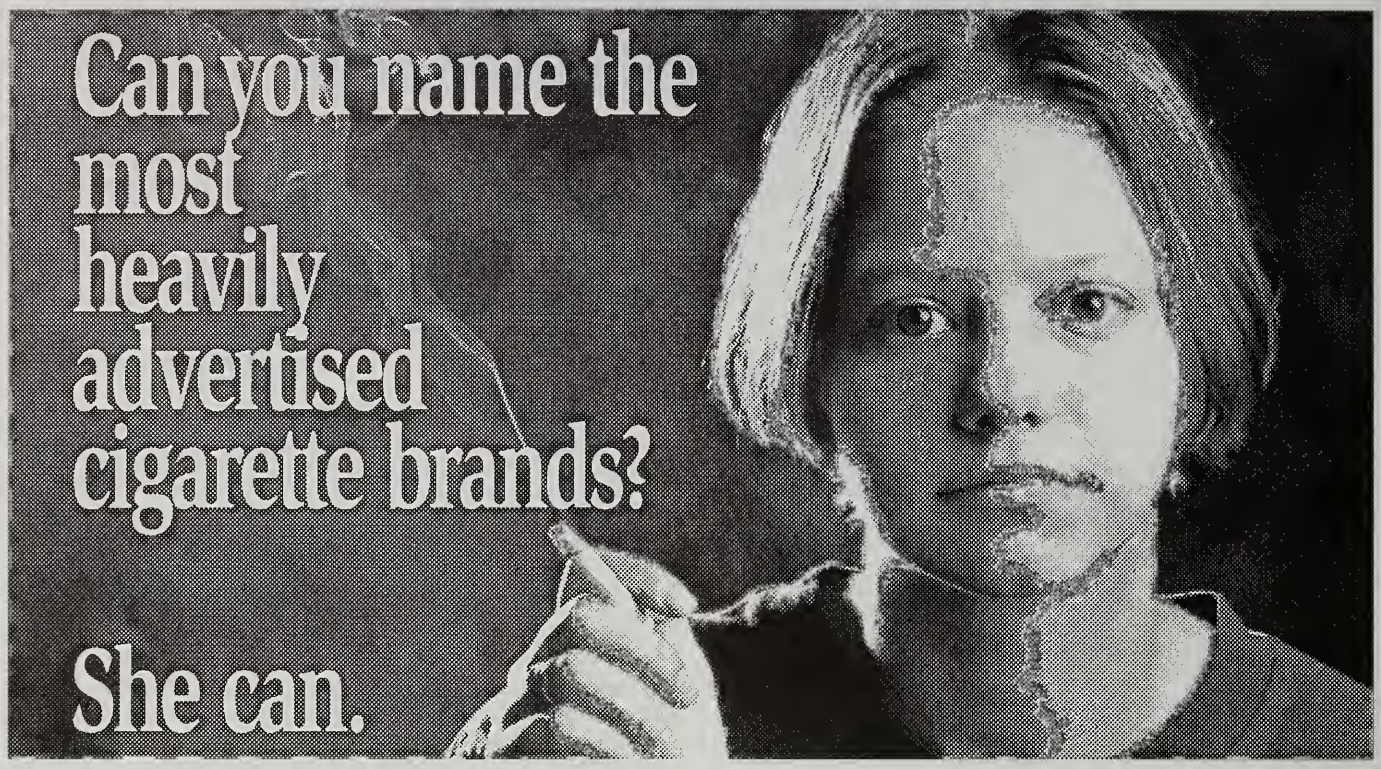
Royalty endorsement income primarily consists of separate endorsement agreements with Medical Assurance (MA) and Acordia of West Virginia to allow them to market services to WVSMA's members relating to various insurance products. WVSMA recognized endorsement royalty income of $115,000 from MA and $48,000 from Acordia of West Virginia in 1995.

6. Retirement Plan

WVSMA is a participant in a Prototype Corporate Defined Contribution Retirement Plan (the Plan). All employees of WVSMA are covered by the Plan as long as they are at least 21 years old and have completed six months of service. WVSMA's contribution approximated $33,000 in 1995 based on approximately 10% of the total compensation of all eligible participants. Employees are vested in their participant account at the rate of 20% for each completed year of service, up to 100% vesting after four years of service.

7. Income Taxes

Revenues of WVSMA are generally exempt from federal income tax under Section 501(c)(6) of the Internal Revenue Code. However, certain income, primarily advertising revenues, is considered unrelated business income and is taxable to the extent revenues exceed allocable expenses. WVSMA paid income taxes approximating $4,500 in 1995.



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- ***Three thousand kids start smoking every day.***
- ***Nearly all adult smokers begin as children.***
- ***One-third will die from their addiction.***
- ***Tobacco companies are making $200 million a year from sales to children and addicting a new generation of customers.***

The nation's top health experts have proposed new limits to keep tobacco marketing from seducing children and to make cigarettes less accessible to kids. But industry lobbyists are scheming to snuff these rules out.

It's time we stopped trusting tobacco companies with our children's lives.

- ***Tell the FDA you support the proposed limits*** *(Food & Drug Administration, Docket 95N-0253, Room 1-23, 12420 Parklawn Drive, Rockville, MD 20857).*
- ***Tell your Members of Congress not to endanger America's children for tobacco company profits.***
- ***Learn more by calling 1-800-284-KIDS.***

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USAF OPHTHALMOLOGIST - Seeks position. Active WV license. For CV, call Charles G. Kirby, M.D., at (803) 775-2480/2470.

STATEMENT OF OWNERSHIP

STATEMENT REQUIRED BY THE ACT OF OCTOBER 23, 1962; SECTION 4369, TITLE 39, U.S. CODE SHOWING THE OWNERSHIP, MANAGEMENT AND CIRCULATION OF THE WEST VIRGINIA MEDICAL JOURNAL.

The names and addresses of the publisher, editor and managing editor are: Publisher, West Virginia State Medical Association, Box 4106, Charleston, WV 25364; Editor, Stephen D. Ward, M.D., Rt. 4 Cloverfields, Wheeling, WV 26003-9804; and Managing Editor, Nancy L. Hill, Box 4106, Charleston, WV 25364.

The known bond holders, mortgages, and other security holders owning or holding one percent or more of the total amount of bonds, mortgages, or other securities are: None.

The average number of copies each issue during preceding twelve months are: (A) Total number of copies printed 3,100; (B 1) Paid circulation through dealers and carriers, street vendors and counter sales: None; (B 2) Paid circulation through mail subscriptions: 2,700; (C) Total paid circulation 2,700; (D) Free distribution by mail, carrier, or other means: 225; (E) Total distributions; 2,925; (F 1) Office use, left-over unaccounted, spoiled after printing: 175; (F 2) Copies distributed to news agents, but not sold; None; and (G) Total 3,100.

I certify that the statements made by me above are correct and complete.

(Signed) Nancy L. Hill
Managing Editor

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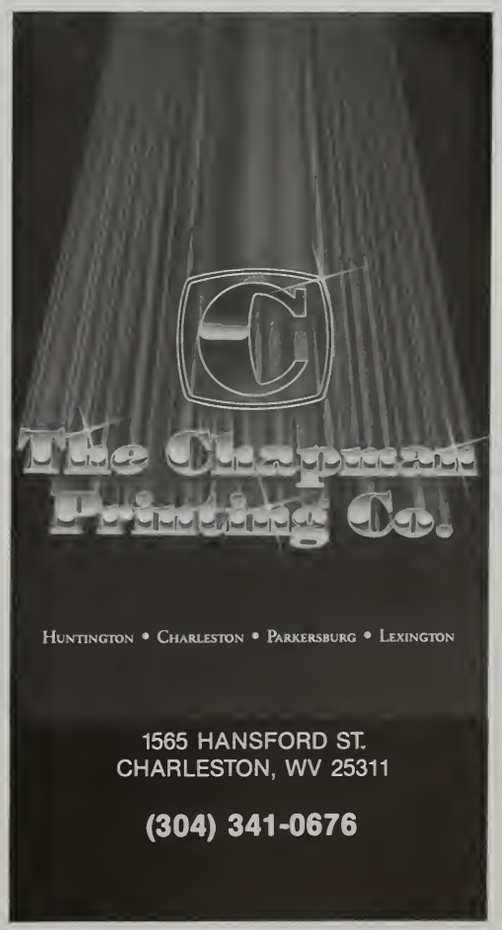

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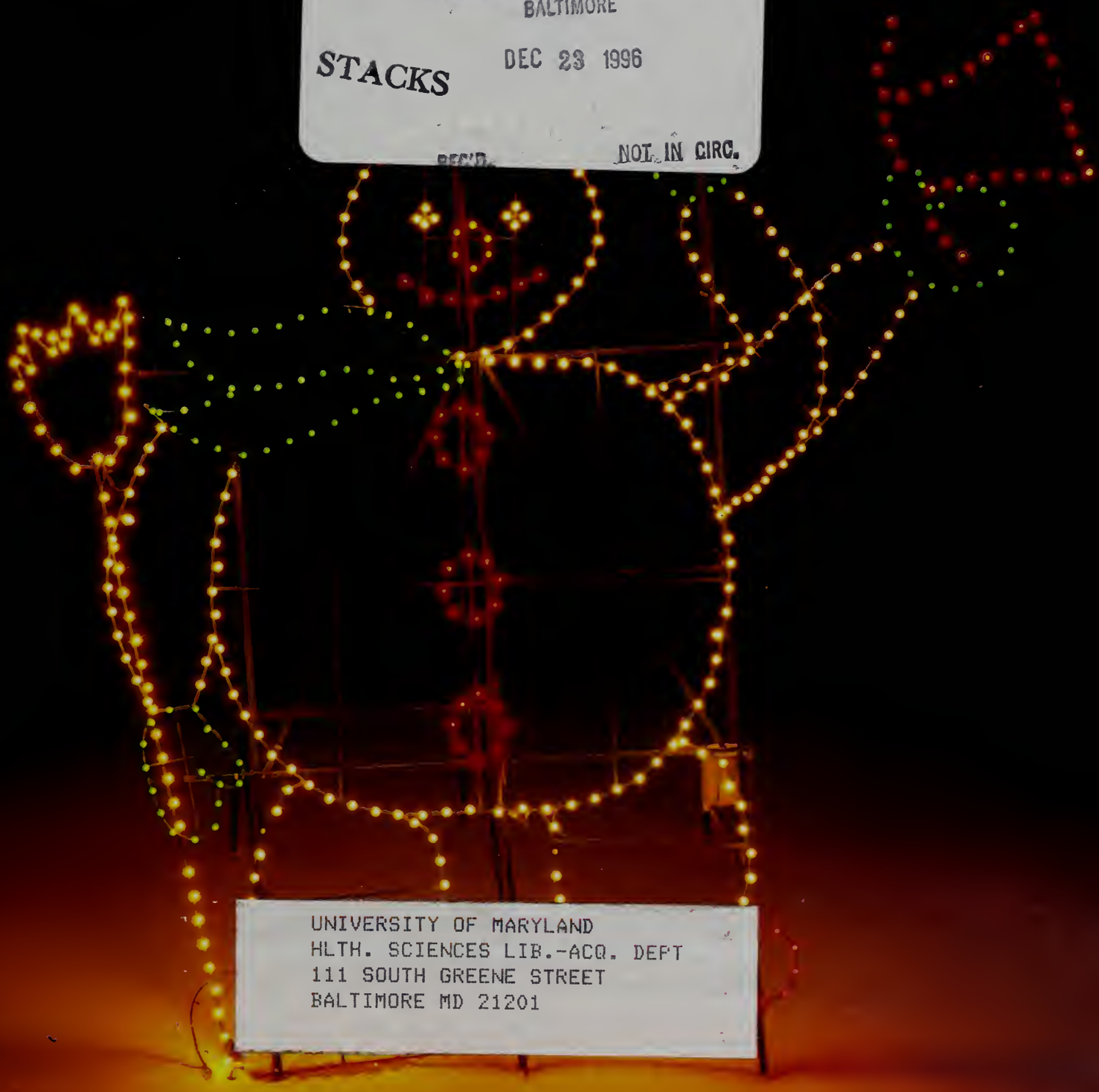

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The **West Virginia Medical Journal** is published bimonthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue SE, Charleston, WV 25304, under the direction of the Publication Committee. Original articles are accepted on the condition that they are contributed solely to the *West Virginia Medical Journal.*

The views expressed in the *West Virginia Medical Journal* are those of the individual authors and do not necessarily reflect the policies or opinions of the *West Virginia Medical Journal*'s editor, associate editors or its staff, or the West Virginia State Medical Association's staff. Publication of an advertisement is not to be deemed an endorsement of any product or service unless otherwise stated.

Subscription Rates:
$45 a year in the United States
$80 a year in foreign countries
$4 per single copy

POSTMASTER: Send address changes to the *West Virginia Medical Journal,* P.O. Box 4106, Charleston, WV 25364.

Entered as second-class matter, January 1, 1926, at the post office at Charleston, WV, under the act of March 3, 1879.

USPS 676 740
ISSN 0043 - 3284

Claims for back issues must be made within the six-month period after publication. Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106.

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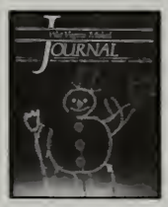

On The Cover

The Festival of Lights at Oglebay Park in Wheeling.

Photo by Stephen J. Shaluta Jr., West Virginia Department of Commerce.

The costs of medicine

How many times have you heard friends or acquaintances complaining about the high costs of medical care? And what has been your response?

Probably, it has been the same as mine - - mumble something about too much government interference and the liability situation and try to change the subject to something more pleasant. However, as physicians we must be able to speak more specifically about some of the reasons for high medical costs and confront one of the major causes - - the lifestyle choices of our populace.

Every day, I see the results of smoking on chest films. More graphically, as I perform vascular procedures, I see stenosed or occluded arteries that require interventions, either surgical or non-surgical. These diseases occur because the patient chooses to continue smoking in the face of years of public education about the hazards of tobacco usage.

My nights are often spent in the hospital dealing with the never ending stream of emergency room patients. Many of these patients have chronic aches and pains or minor medical problems that could be cared for much less expensively and more efficaciously in a physician's office or clinic. Others are the victims of trauma, often involving motor vehicles and, more often than not, involving alcohol.

Evidently the word has not spread to a large segment of our population that one does not drink and drive. Too many of our citizens feel that it is an imposition upon their personal liberties to wear seat belts. The resulting medical costs from accidents involving alcohol and/or lack of seat belts are astronomical.

The toll on families in our state is great - - both economically and emotionally.

In our offices every day, we see far too many patients who are overweight and who never exercise. The medical costs of this population are also huge, as these patients require chronic care for the resulting hypertension, diabetes, and heart disease. While I am proud of the ability of the large heart disease programs in the state to care for these patients, I am saddened and chagrined that this small state has such an unhealthy population that we need such large programs.

The bottom line is this:

We, the physicians of West Virginia, must aggressively counsel our patients every day about appropriate healthy lifestyle choices, both in our private consultations with them and also in the more public forums of our communities. It is our duty to be at the forefront in publicizing the costs of poor and inappropriate lifestyle choices to our schools, churches, civic, and other groups. Indeed, we must advocate for changes in our communities which will improve the health of our citizens, such as promoting safe and age appropriate exercise programs for the elderly in senior citizen centers and facilities, or encouraging both child and adult bicyclists to wear helmets when riding. Our county medical societies can be the catalysts to begin these public educational activities.

As we take on this added responsibility to more visibly support healthier lifestyles, we will have the opportunity to also publicize the links between poor lifestyle choices and the high costs of insurance and medical care. We must also relate these exorbitant costs to the tort "lottery" system (but that will be the central theme of a future column). While we have their attention, we can remind them that physicians' charges only account for approximately 20% of total medical costs in this country.

Let's get more publicly involved in our communities! The rewards will be great. Not only will we improve the health of our patients, but we can increase understanding of and support for our legislative efforts such as tort reform and the Patient Protection Act.

Ronald E. Cordell, M.D.

P.S. Always remember - - we are physicians, not providers. Only physicians are trained to provide medical care - - not administrators or insurers. We should derive our strength and our unity as professionals from this knowledge.

Good medicine

So, what is Medicine to do now that the country is apparently stalemated politically and the state of West Virginia tending in that direction? We can start off by being thankful that the results were not a whole lot worse. We and our patients faced twin disasters in both Charleston and Washington.

It is certainly not a time to sit back and congratulate ourselves or to be in any way discouraged at the election results. There is no evidence in the congressional elections that the conservative tide which for some years has been gathering strength was even partially blunted. There is solid evidence that government intrusiveness into our personal lives and decisions is becoming universally resented.

Medicine was on the right side and without doubt performed valuable service, particularly in the governor's race, but the makeup of our Legislature is still woefully unbalanced and our congressional delegation is distressingly onesided. West Virginia, strangely, is about the last of the supposedly southern states which made up the "Solid South" for the Democratic party for so many years. There is no more "Solid South," and, we hope, Governor Underwood's election heralds the demise of the last vestiges of that coalition in this state.

The race for governor was, for West Virginia, a political aberration reflecting more a deep division in Democratic ranks rather than any real Republican strength. There is just no other way of putting it, there are simply too many Democrats in West Virginia to assure consistently good government. If voting registration figures were reversed, we could make the same statement while substituting "Republicans" for "Democrats." There is no more effective safeguard for good, honest government than the possibility of being thrown out of office at the next election. For Democrats in West Virginia that is hardly a risk.

Political affiliation needs to be based on something other than family tradition. That is not the case in West Virginia. What to do about it is a real problem. Big Labor has seen its political influence over its members dwindle. Old bigotries and myths in other parts of the country have fallen. Even racial and ethnic patterns of voting have begun to crumble. These changes have been accompanied by a leveling of political party influence. In every instance, economic development successes have preceded the political changes.

Perhaps it is economic development that has brought about this political boon. West Virginia, recognizably, one of the least economically developed states, on the basis of such a theory might be expected to be politically retarded. If true, in Cecil Underwood we have a valuable instrument who, though his economic development plans, could bring about a long delayed political party revolution in West Virginia with an effect benefitting every citizen of this state.

Presently, it is our primary task to work towards a better political climate for Medicine in West Virginia. Governor Underwood's economic development plans could provide a vehicle for our movement in that direction. We should support and participate in those plans in any way possible. It will be good medicine for West Virginia.

Stephen D. Ward, M.D.
Editor

Your memory/your patient's memory and your medical records

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Senior Risk Management Specialist, Medical Assurance of West Virginia, Inc.

Too much emphasis can never be placed on the importance of timely, accurate, legible, comprehensive, objective and professional documentation to medical records. Not only is it good for patient care purposes, but it allows for the maintenance of significant details should questions on care occur in the future.

Professionals who observe and render care and treatment to patients will be unable to remember all patients or the individual facts about situations surrounding the professional services rendered, but the individual patient will remember. Each individual patient, whether it be right or wrong, will have a personal opinion or conviction, influenced by family or friends regarding the acceptability of the care and treatment rendered, or which should have been rendered from the health care provider.

Many physicians communicate effectively in oral discussions with patients and other practitioners, but are less effective when documenting medical care and conversations relating to medical care. Shorthand notes or abbrevations, seem sufficient at the time, but more often the physician cannot remember years later the important details these brief notes were intended to summarize. Juries tend not to accept a physician defendant's recollections about undocumented medical care, treatment and conversations with patients. Also, juries give little credibility to additions to the medical record after a patient has been injured or files a lawsuit.

The importance of the medical records, both in the medical office and the hospital, is significant because medical malpractice lawsuits may come to trial anywhere from two to 10 years after the alleged incident. At that point, the defendant physician will likely have very little memory of contact with any particular patient. Therefore, the medical record is the only evidence to tie the facts together, when the patient was under the physician's care. The medical record becomes invaluable to the defense because memory alone is not enough. The following case is a prime example:

A mother with a crying three-year-old child told the triage nurse the child had something in his left ear. The emergency physician attempted to remove the foreign body but was unsuccessful, then referred the child to an ENT. The ED physician later called the ENT to learn that the child sustained a perforated ear drum, and probably would have permanent hearing loss.

In reviewing the medical record, the triage nurse's narrative note read - - *"Three year old with mom. FB left ear."* The physician's note read - - *"Unable x2 remove FB L ear. Fussy kid. Refer ENT."*

The ED physician offered these undocumented facts:

*The child's mother informed the doctor that she attempted several times to remove the object with a Q-tip. *(The physician, though, did not inquire how many times the mother probed the ear with a Q-tip, when in fact, the mother may have pushed the object deeper in the ear and caused the perforation.)*

*When the physician examined the boy's ear, he screamed and was extremely combative, until he was restrained. *(The physician, though, did not describe the appearance of the child's ear, did not mention what instrument was used to attempt to remove the object, and did not document that the child was fidgeting and uncooperative.)*

The ED physician probably did not cause the child's injury, but the medical record does not support the facts. The mother's deposition contradicts the physician's undocumented memory of the facts which creates a difference of opinion and a question of who is the most believable. The ED physician's documentation may appear reasonable, but lack of thoroughness could have led to the patient's injury and compromised the defense in the event of a lawsuit. But, if the foreign body had been removed from the child's ear without an adverse result, the documentation, while not very detailed, would have been considered sufficient according to peer reviewers.

Given the critical importance of having a strong malpractice defense at all times, Medical Assurance Risk Management Services has developed risk management programs which assist physicians in reducing and eliminating risks that expose them to malpractice lawsuits, including the rules for effective documentation which appear on the opposite page.

For more risk management information, please feel free to phone me at (304) 522-0601 or fax me at (304) 522-0602.

Rules for Effective Documentation For All Medical Records

A. Write Legibly.

The entry and the signature should be readable.

B. Be Contemporaneous.

Written at the time of the event.

C. Put Full Name and Medical Record Number of Patient On the Page.

Do not document on any page not properly identified with this information. Do not use only the last name of the patient to identify the record since there may be more than one patient with that name.

D. Write only with a ballpoint pen using black or blue ink.

Never use pencil and avoid felt tip markers which may bleed through the page and obliterate entries on the reverse side.

E. Supervise Residents, Physician Assistants, etc.

Notes written by residents, physician assistants, etc., should reflect supervision by the attending physician. The person who writes such a note should include a notation that the case was discussed with the attending physician. An attending physician should countersign resident's notes to demonstrate supervision and involvement in the care.

F. Communicate With the Patient or Responsible Adult.

Notes should reflect that the patient was kept informed of his/her illness and the treatment plan. There should be notes regarding informed consent and patient teaching.

G. Avoid Obliterations, Erasures or Any Alteration of Records.

Any corrections should be made by drawing a single line through the erroneous entry, document error and initial, and date.

H. Make Sure the Date, Time and Your Signature Are On All Records.

This is especially important when a patient's condition changes suddenly.

I. Progress Notes.

1. *Be specific* - Avoid general terms like "pt OK," and "doing well." Document specific impressions like "neuro status improving," or "neuro signs normal."
2. *Be objective* - Avoid labels such as "uncooperative." Instead, define behavior as "patient refuses to remain on bedrest."
3. *Tell a story* - By reading progress notes, a caregiver should be able to discern the sequence of events in the patient's care and the patient's progress. To help maintain continuity, read the last one or two progress notes before writing a note to keep the story cohesive and avoid gaps.

J. Consultations.

1. All consults should be requested in writing and give the consultant a summary of information available regarding the patient's problem.
2. All consultation reports should be complete, thorough, accurate and clearly document recommendations for treatment.
3. If a consultation report is not made at the time the patient is seen, a brief note should be written by the consultant in the progress notes indicating pertinent findings and recommendations. State that a complete report of the consult will follow.
4. Consultations received should be acknowledged in writing progress notes i.e., "Recommendations from Infectious Diseases noted."
5. If recommendations from the consultants will not be followed, clearly and objectively document this and the reasons why.

K. Admitting histories and physical examinations.

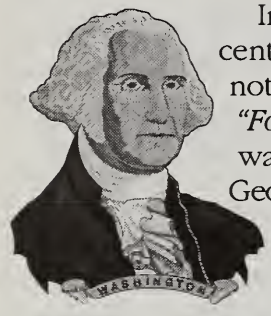
A well-documented admitting history and physical includes the following:

1. Date, time and signature.
2. Identity of the person from whom the information was obtained and some assessment of his/her reliablity. For example, "History obtained from husband who is vague about patient's past illnesses."
3. Complete medical history using quotes when possible to describe pain or other symptoms.
4. Complete review of systems covering all organ systems, not just those involved in the presenting complaint. If patient refuses any portion of the exam, this should be noted.
5. Impressions or provisional diagnosis. "Rule Out" diagnoses should be used sparingly since they must later be excluded in writing in the medical record - only the real possibilities should be included.
6. An initial plan for treatment, together with some notation that this plan was explained to the patient.
7. If written by a resident or physician assistant, there should be some notation that the admitting history and physician and initial treatment plan was discussed with the attending.

Ten rules of civility for the medical warrior

TIMOTHY LESACA, M.D.
Assistant Clinical Professor of Psychiatry, Medical College of Pennsylvania, Allegheny Campus, Pittsburgh; and Psychiatrist, Staunton Clinic, Sewickly, Pa.

Introduction



In the late 19th century, a school notebook entitled *"Forms of Writing"* was discovered at George Washington's plantation home in Mount Vernon, Va. The notebook dates from around 1745, when Washington was about 14 years old and attending school in Fredericksburg, Va.

Inside, in Washington's own handwriting, were found some 110 *"Rules of Civility in Conversation Amongst Men."* He most likely copied them from a 1664 English translation of an even older French work. The rules are solid guides of personal conduct that encourage respectful speech and behavior, humility, avoidance of malice and gossip, appropriate social boundaries, and tolerance for the beliefs and feelings of others (1).

General Washington's successes in diplomacy and politics are testaments to the value of applying rules of civility to our daily lives. Although Washington's battle victories at Trenton, Princeton, and Monmouth brought him acclaim, I believe his most meaningful victories occurred in the countless interpersonal interactions he negotiated every day.

Similarly, each of us must face many thousands of brief interactions over a lifetime. Each interaction is a test of our skill and armor. Every contact has the potential of being a victory over Lord Cornwallis or a long and cold winter at Valley Forge.

In the field of medicine, we face a daunting challenge. In our offices where we wage the battle against disease and human suffering, we interact with potentially thousands of patients over a year. Each patient deserves our maximum potential and undivided attention. Unfortunately, financial and societal pressures often allow us only minutes to interact.

Considering the major challenge of battling disease, the large number of patients we treat, and the fact that we fight this battle with progressively diminishing time and resources, one casualty of the war could be our civility. With this in mind, I propose these *"Ten Rules of Civility for the Medical Warrior."*

1. WHEN GIVEN THE CHOICE BETWEEN LISTENING AND SPEAKING, ALWAYS LISTEN FIRST.

In the practice of medicine, we often act from the false assumption that our patients always expect from us a profound response to their questions. Often the patient's greatest desire is simply to be understood. By listening rather than speaking, we show a willingness to understand.

2. WHEN APPROPRIATE, NEVER MISS AN OPPORTUNITY TO APOLOGIZE.

The patient's complaint is his perception, and his perception will always be his reality. We need not inappropriately accept blame, but we should express regret for his unpleasant experience. By doing so, we recognize his humanity, and show our own.

3. TREAT ALL QUESTIONS WITH EQUAL CONCERN.

When a patient asks a question that initially seems trivial or irrelevant, we must not forget that this question likely represents a concern important to the patient. He would otherwise not be asking it.

4. ALWAYS FIND SOMETHING POSITIVE TO PRAISE ABOUT YOUR PATIENT.

Our patients choose to view us as having great power. As the holders of that power, we have the capacity to do much good and cause great pain. Our moral responsibility is to modulate that power with kindness.

5. SPEAK BADLY OF NO ONE.

In the battle against disease there are many enemies. Sometimes our patients broaden the battlefield by proclaiming that their previous physicians, their insurance companies, and others are also the enemy. No matter who the enemy is, we will not shorten the battle by throwing insults in the presence of our patients.

6. TREAT EVERYONE WITH EQUAL CONCERN.

No one will freely admit that he is prejudiced. We must nonetheless be wary of the possibility that we take the complaints of certain patients more seriously than those of others based upon their age, gender, race, financial status, or affliction.

7. ALWAYS RESPECT YOUR PATIENT'S PRIVACY.

Laws exist to protect medical records, but no laws exist to protect against poor social skills. Avoid the

temptation of saying loudly, "Don't forget your barium enema tomorrow," as your patient is walking through your crowded waiting room toward the exit after your appointment. That is, unfortunately, a true story.

8. MAKE YOUR PATIENT THE MOST IMPORTANT PERSON IN THE WORLD TO YOU AT THAT MOMENT.

Many ways exist to offend your patient by accident, such as looking at your watch or the clock on the wall, not making eye contact, not addressing the patient by name, and being late without an apology, to name a few.

9. BE CAUTIOUS WITH YOUR SENSE OF HUMOR.

One of the biggest handicaps in meeting someone for only a few minutes is that you cannot fully appreciate that person's emotional sensitivity. Despite the circumstances, laughter can be misinterpreted by your patient as disinterest or that you think his concerns are trivial.

10. EMPOWER YOUR PATIENT TO END THE APPOINTMENT.

We can empower our patients by simply asking, "Is there anything else I can do for you today?" That question gives the patient the power to allow you to leave. In a meeting that lasts only a few minutes, this empowerment is vitally important. Our actions betray our words, however, when we stand and grasp the doorknob as we ask the question.

In closing, I must swallow my own jagged pill. I, therefore, apologize to those who found reading this article offensive. I do not pretend to be a knight in shining armor. Instead, I hope to share with my fellow warriors what I have learned from shooting myself in the foot repeatedly during battle.

Tomorrow, when you have seen your 25th patient of the day and are marching back to your crowded waiting room to say "Next, please," I only hope that you will reflect kindly upon this paper as a prayer for peace.

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Atypical presentation of a dermoid brain cyst

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Abstract

This article describes the case of a dermoid cyst with unique radiological findings in an unusual location. This cyst arose from the anterior clinoid process and projected into the right frontal lobe in a 39-year-old man. CT and MRI revealed a gravity dependent level within this low density lesion. Stereotaxic biopsy revealed that this gravity dependent level was formed between layers of fat and fluid. Craniotomy later showed the presence of hair within this lesion. The literature concerning the radiographic findings and location of dermoid brain cysts is also reviewed.

Introduction

Many types of intracerebral cystic lesions exist, but the major ones are tumor, abscess and arachnoid cyst. Since it is often difficult to differentiate these lesions by radiographic techniques, a biopsy is necessary for a definitive diagnosis.

These three types of lesions may have certain characteristic clinical and/or radiological presentations. For example, a malignant brain tumor may present as a rapidly progressive focal deficit, and cerebral abscesses typically display a focal deficit associated with constitutional signs. All of these lesions can cause seizures.

Radiographically, malignant brain tumors often show heterogeneity. These non-homogeneous can have cystic areas surrounded by a shell of contrast enhancement. In addition, a penumbra of edematous brain associated with a midline shift may also be present. Cerebral abscess may show an air-fluid level and this "air" is carbon dioxide gas associated with the anaerobic organisms.

The treatment for malignant tumors is complete surgical resection, radiosurgery, or radiation (1). Cerebral abscesses are typically treated with surgical drainage and intravenous antibiotics. Asymptomatic benign cysts are usually left alone.

This article presents a case where a dermoid brain cyst simulated a brain abscess on CT. This cyst had a gravity dependent level which appeared to be an air-fluid interface. Neurosurgery revealed that this level was the interface between fat and fluid layers associated with a dermoid cyst. Since abscesses and dermoid cysts require very different treatments it is critical to make a diagnosis with stereotactic brain biopsy and/or surgery.

Case Report

A previously well 39-year-old man presented with an acute severe right-sided headache associated with blindness in the right eye. He had awakened that morning with these symptoms. There had been a progressive decrease in vision in his right eye over three months, but he had not experienced headaches.

This patient also complained of chills, nausea and fever but denied photophobia. His past medical history included a lumbar disc herniation eight years prior.

On examination he was awake and oriented. He had light perception only in the right eye. His right pupil was sluggish in its reaction to light and was slightly dilated at 5 mm in room light when compared to his left which was 3 mm. All other cranial nerves were intact. He had no other neurological deficits.

Enhanced CT scan and the MRI (Figures 1,2) revealed a right frontal lobe mass with an apparent air fluid level consistent with a cerebral abscess. He was started on I.V. antibiotics.

A stereotactic-guided needle biopsy was then accomplished. The lesion was noted to have a firm capsule and 20 ml. purulent yellow fluid was aspirated.

Another CT scan was performed and seven days later a fronto-temporal craniotomy for evacuation of the lesion was performed. The lesion appeared to arise from the anterior clinoid process and right sphenoid bone. Hair was seen in the mass so the diagnosis of a dermoid brain cyst was confirmed. Permanent histologic sections (Figures 3,4) revealed squamous epithelium lining the cavity. No adnexal structures were demonstrated.

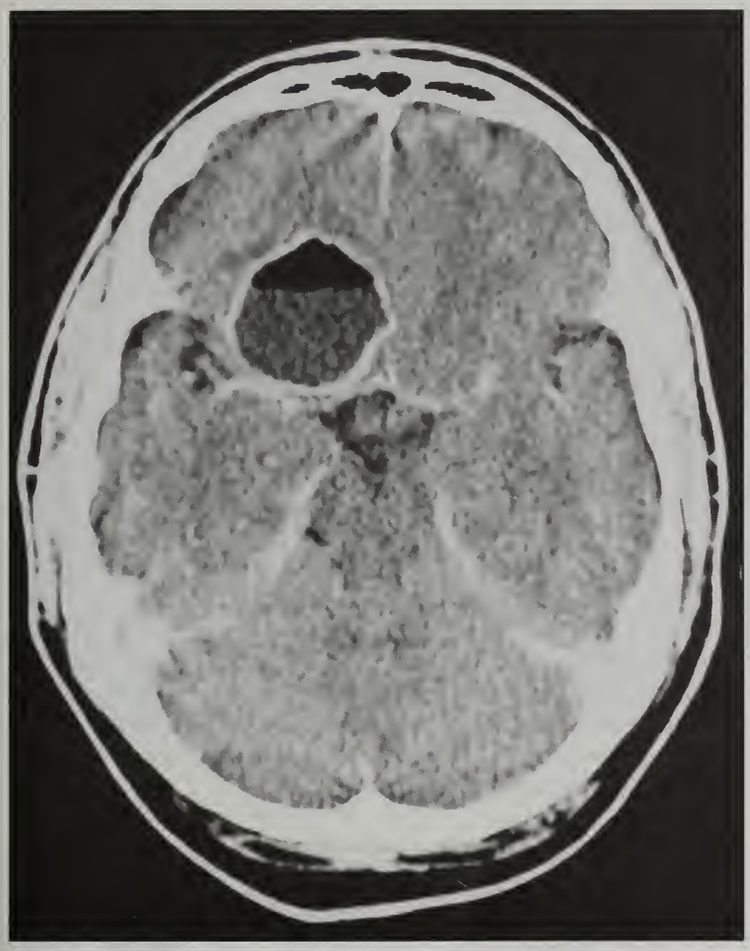

Figure 1. **Enhanced CT scan reveals a right frontal lobe lesion with a fluid level. A shell of calcium surrounds the lesion. No midline shift or edema is demonstrated.**

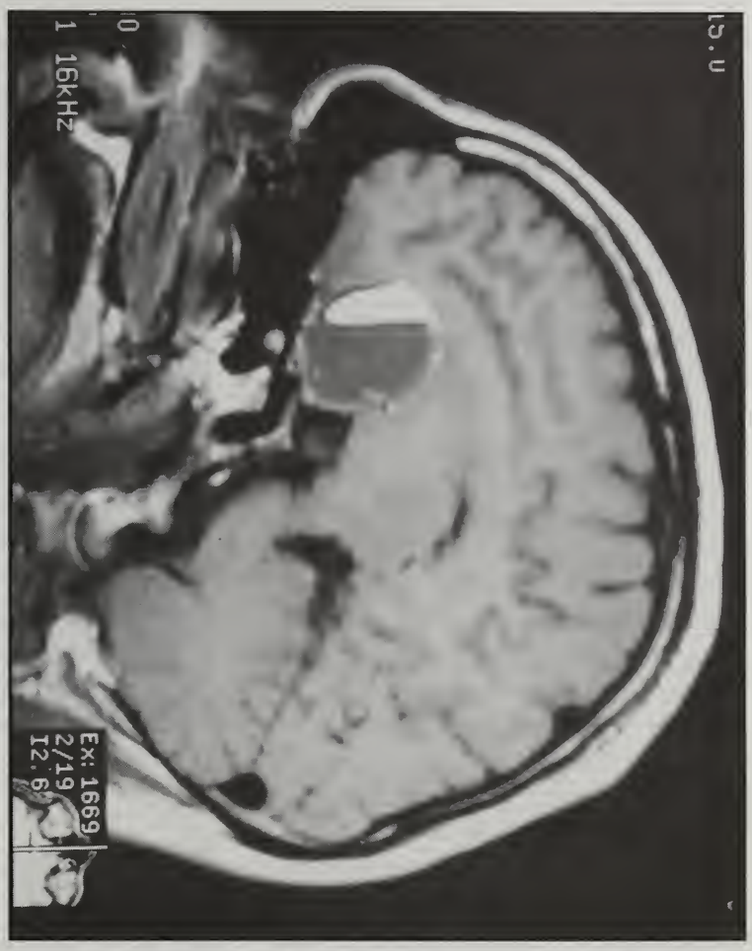

Figure 2. **Saggittal view of MRI scan demonstrating the different densities of the two fluids within the lesion.**

Postoperatively, this patient's vision completed returned and he remains tumor free.

Discussion

Epidermoid and dermoid cysts arise from misplaced epithelial cells (2,3). These inclusions of ectoderm become misplaced during the third through fifth weeks of embryonic life (1,2).

Cells that become misplaced early tend to give rise to deeper lesions. Later lesions tend to be more superficial. These lesions may also arise as a result of iatrogenic tracking of skin into the CNS during lumbar puncture or brain biopsy (3,4).

Dermoids occur less often than epidermoids. They represent 0.3% of all intracranial tumors (2). Dermoids tend to occur in the midline (1) while epidermoids are frequently found laterally. Dermoid cysts contain deeper skin adnexal structures such as hair and sweat glands. Treatment of both epidermoid and dermoid cysts is total resection (3,9).

Lesions that arise from transplanted epithelium have a growth rate which compares to that of the skin which generates a new population of cells each month. As a result these cysts usually present with symptoms related to focal neurologic or mass effects (3,9). If the cyst bursts, extruding its irritating contents into the ventricular system, a chemical irritation syndrome may occur (3,5,9). The three-month history of visual loss in the right eye in our case is consistent with the growth of the lesion.

Inclusion cysts are relatively rare and represent only 1% of all intracranial tumors (5,8,9). These cysts have been demonstrated within the skull bone, meninges, and neural parenchyma. Epidermoids typically occur around the cerebellar-pontine angle (1,2,3,5,9). Dermoids are usually restricted to the posterior fossa (1,2,3,9) and are typically found within the fourth ventricle or in the midline between the cerebellar hemispheres (1,3). In our case, the lesion arose from the anterior clinoid process and projected into the right frontal lobe. The anterior fossa is an uncommon location.

Spine dermoids and epidermoids can be associated with fistulas to the overlying skin. These fistulas are similar to dural sinus tracts by creating a route for infection which can lead to meningitis (2,9). A case was reported in which such a fistula allowed air to enter the cyst forming a true air-fluid level (3). The presence of this patent tract may confound a timely diagnosis. Cases like ours in which the patient had no fistula and no constitutional symptoms demonstrate the value of biopsy in making a exact diagnosis.

The epidermoid and dermoid brain cysts are indistinguishable on CT and MRI, and both lesions are

low density on CT. They commonly have peripheral capsular calcification (1,3). Both types of cystic lesions are devoid of blood supply and calcification occurs only within their capsule. Our case had a thin shell of calcium on CT scan. Some authors have suggested that the center of these lesions may also become calcified secondary to an infection, but this is a rare occurrence (1).

Inclusion cysts may also display a gravity dependent fluid level, from either an air-fluid or fat-fluid interface. It is not possible to differentiate between air and fat on MRI or CT without first using a computer to determine slight density differences. This computation must be done at the time of the scanning while the image is still digitalized. These lesions may be confused with abscess when such levels are present. Preoperatively, we assumed that the lesion was an abscess and that the gravity dependent level was an air fluid interface. Therefore, the densities were not measured at the time of the scan.

At surgery, the epidermoid typically displays a "mother-of pearl" whiteness in its capsule (1,3). Dandy referred to this as "the most beautiful tumor in the human body" (6). The dermoid is typically more disagreeable with hair occupying the center of a greasy brownish capsule.

The dermoid specimen is typically cheesy and pilosebaceous. These lesions are often called buttery tumors because of their yellow fat content and slippery nature. Histopathologically sweat and sebaceous glands with hair are seen in dermoids alongside keratinized epithelium (3). The epidermoids only contain the squamous cell components.

As demonstrated in our case report, it is sometimes invalid to assume that small sections of a lesion are representative of the lesion in entirety. There have been a few reports of malignant transformation of epidermoids but this is a rare occurrence (3).

Figure 3. **Microscopic view of the cyst at 100X magnification demonstrating stratified squamous epithelia lining the cavity.**

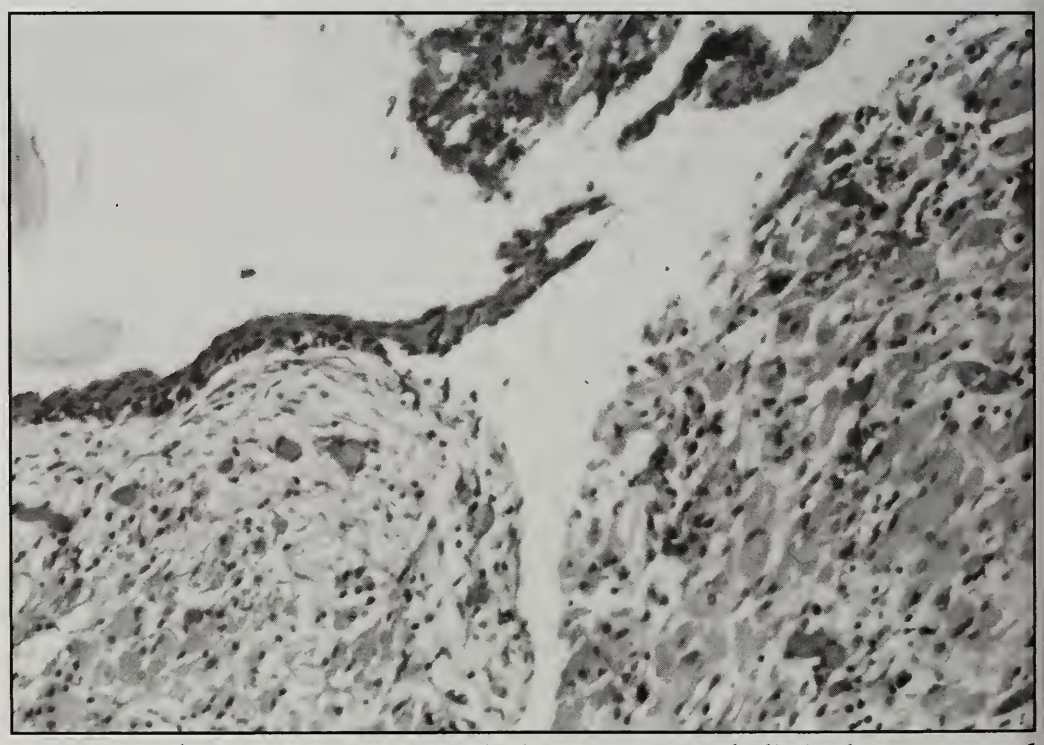

Figure 4. **At 400X, the layer of stratified squamous epithelia is shown. Dermal appendages such as sebaceous glands, hair follicles and sweat glands were not found histologically, but hair occupied the cavity at surgery.**

The goal of surgery is to obtain complete resection of the cyst and its wall (3). This is often difficult because of adherence to blood vessels or cranial nerves. Yamakawa et al (9) reported survival status post epidermoid resection of 92.8% at 20 years. Guidetti et al had no deaths in their series of 21 dermoids (7).

Conclusion

We conclude that brain biopsy and/or surgery is essential for the definitive diagnosis and initiation of appropriate treatment of intracereberal lesions.

We have described an unusual presentation and location of a

They commonly dermoid brain cyst. A timely diagnosis of this lesion may not have been made without biopsy. This lesion appeared to be a brain abscess preoperatively.

We suggest considering the diagnosis of dermoid brain cyst when faced with a gravity dependent level on CT or MRI. We also suggest that dermoid cysts may not be confined to the posterior fossa as was previously thought.

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Autoimmune hepatitis in children

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Abstract

Autoimmune hepatitis (AIH) is usually diagnosed after other viral, metabolic or drug-induced etiologies have been ruled out. Although uncommon in children, the disease can manifest itself with severe hepatocellular damage and early fibrosis. Early diagnosis and aggressive treatment may improve morbidity and decrease mortality. In other cases, liver transplantation is the final rescue for these children. We describe our experience with five children who were diagnosed with autoimmune hepatitis. Their diagnosis, medical treatment and clinical outcome are presented with a review of the literature.

Introduction

Chronic hepatitis is a diverse syndrome characterized by abnormal liver function tests. It is associated with clinical signs of chronic liver disease and with histological evidence of ongoing hepatic inflammation.

Viral, metabolic or drug induced hepatitis are the common causes for chronic liver disease. Although autoimmune hepatitis (AIH) is the least common cause of hepatitis, it is more commonly seen in younger patients (1,2).

The diagnosis of AIH is established by exclusion of viral, metabolic or drug-induced hepatitis and the demonstration of elevated levels of serum auto-antibodies (3). Although there are no pathognomonic histological features, liver biopsy is helpful to confirm the diagnosis (4).

AIH in children has three distinct subgroups. AIH type 1 is characterized by high serum anti-smooth muscle antibodies, AIH type 2 is characterized by high titers of anti-liver-kidney microsomal antibodies (anti-LKM) (1,5,6), and AIH type 3 is indicated by positive anti-soluble liver antigen (7). Treatment of AIH consists of steroids and immunosuppressive drugs or liver transplantation for end stage liver disease.

To alert primary care physicians to this uncommon disease, we report five pediatric patients with autoimmune hepatitis. Their clinical presentation, laboratory results, treatment and outcome are presented.

First case

T.D. is a 15-year-old girl with a history of jaundice and loss of appetite of two months duration. Initial examination revealed abdominal tenderness, icterus and hepatosplenomegaly.

Laboratory tests showed anemia, abnormal liver function tests and elevated autoantibodies (Table 1). Serum ceruloplasmin was 50 mg/dl. EBV/CMV/HSV/Toxo/Rubella antibodies and Hepatitis A,B,C serology were negative. Alpha 1 anti-trypsin was negative.

Liver biopsy showed acute and chronic inflammation in the portal area extending into the parenchyma with evidence of micronodular cirrhosis. The diagnosis was autoimmune hepatitis and she was started on Prednisone 30 mg/day. Due to failure of steroid treatment, she was started on Azathioprine (Imuran) five months later and prednisone was tapered to a minimal level.

After four years of treatment, she is asymptomatic and treated with Imuran 50 mg and prednisone 10 mg daily. Her recent lab results included: total serum bilirubin 0.9 mg/dl, total protein 7.6 gm/dl, albumin 3.8 gm/dl, SGOT 59 u/l, and SGPT 84 u/l.

Case 2

D.S. is a 14-year-old boy with a history of jaundice and abdominal pain for six months. His initial physical examination was normal and laboratory results showed abnormal liver function tests with prolonged coagulation time.

Serological tests for hepatitis A, B, and C were negative, as were viral studies including CMV and EBV. Ceruloplasmin and alpha-a anti-trypsin were also negative.

Autoimmune studies showed elevated serum anti-nuclear antibodies (ANA) and anti-smooth antibodies (ASA). Anti-thyroid antibodies (microsomal/thyroglobulin) anti-mitochondrial (AMA) and anti-liver-kidney microsomal (anti-LKM-1) antibodies were negative (Table 1).

Initial liver biopsy showed micronodular cirrhosis with severe chronic active hepatitis. He was treated with prednisone (30 mg/day) and liver function tests were monitored. Several attempts to taper his steroid treatment were

Table 1. The Clinical Presentation of the Five Patients With Autoimmune Hepatitis.

	Case 1	Case 2	Case 3	Case 4	Case 5
Age (Years)	15	14	13	13	13
Sex	Female	Male	Female	Male	Female
Jaundice	++	++	++	+	+
Anorexia	+	+	+	+	+
Abdominal Pain	+	+	+	+	+
Fever	-	-	+	-	-
Duration	2 months	6 months	3 months	1 week	2 weeks
Abdominal tenderness	+	+	+	+	+
Hepatosplenomegaly	+	-	-	-	+

unsuccessful as his total bilirubin and liver enzymes increased. After 10 months, azathioprine was started and the steroid was tapered.

For the last five months, he has been clinically stable with imuran (100 mg/day) and prednisone (10 mg/alternate day). His recent liver function tests showed bilirubin 2.0 mg/dl, total protein 9.5 g/dl, albumin 4.8 g/dl, alk. phosphatase 169 u/l, SGOT 57 u/l, and gamma-GT 148 u/l. A repeat liver biopsy showed chronic inflammation, fibrosis and regenerative nodules (Table 3).

Case 3

S.S., a 13-year-old girl, had a history of jaundice for three months associated with mild fever, anorexia and nausea. Initial examination showed obesity and mild icterus.

Lab results showed elevated liver function tests and elevated autoantibodies including anti-smooth muscle, anti mitochrondial, and anti-thyroid antibodies (Table 1). Serological tests for hepatits A, B, and C were negative. Ceruloplasmin and alpha-1 anti-trypsine were negative.

Liver biopsy showed extensive fibrosis and active chronic inflammation with numerous eosinophils and plasma cells. She was treated with prednisone (45 mg/day) and responded slowly. Due to severe steroid side effects, Azathioprine 50 mg/day was added six months later and prednisone was successfully tapered down to 5 mg/day. The patient continued to improve clinically and histologically (Table 2).

After four years of follow-up, the patient stopped treatment and developed severe liver failure with icterus, splenomegaly, bleeding varices, ascites and peripheral edema. Lab results at that time showed total serum bilirubin 1.5 mg/dl, albumin 3.1 g/dl, SGOT 63 u/l, alk. phosphatase 161 u/l, and prolonged P.T. and P.T.T.

She was transferred to a liver transplant center by her primary physician and in September 1995, had an orthotopic liver transplantation. Since then, she has been lost from our follow-up.

Case 4

C.M., now a 26-year-old man, presented initially at age 13 years with abdominal cramps, diarrhea and fatigue. Physical exam was unremarkable except for mild icterus.

Lab data showed total serum bilirubin 3.3 mg/dl (direct 1.4 mg/dl), total protein 9 g/dl, albumin 4 g/dl, SGOT 350 u/dl, SGPT 466 u/dl. Hepatitis A, B, C tests were negative. Anti-smooth-muscle antibody (ASA) and anti-mitochondrial antibody (AMA) were elevated, but anti-LKM antibody was negative (Table 1).

Liver biopsy at that time showed chronic active hepatitis with fibrosis and inflammatory infiltrate (Table 2). He was given prednisone 60 mg/day and azathioprine 75 mg/day was later started to decrease side effects of prednisone.

This patient responded clinically and a repeat liver biopsy (1992) showed decreased inflammation with a mild increase in fibrosis. Laboratory results showed total bilirubin 0.4 mg/dl, SGOT 39 u/l and SGPT 41 u/l.

His current medications include azathioprine (25 mg/day) and prednisone (2.5 mg/day). Recent laboratory data (April 1995) showed: total bilirubin - 1.4 mg/dl, total protein - 7.8 g/dl, albumin - 4.4 u/dl, SGOT - 26 u/l, gamma-GT - 51, PT - 11.6, PTT - 25. His last liver biopsy (1994) showed decreased inflammation with no increase in fibrosis (Table 2).

Case 5

P.D., a 13-year-old girl was referred to the gastroenterology service at the Marshall University School of Medicine with complaints of fatigue, jaundice and abdominal pain for two weeks. She had visited the Emergency Department of a local hospital where she was treated with amoxycillin for the diagnosis of acute pharyngitis.

After a few days, the jaundice deepened, and she was referred to us for further evaluation. Her past medical history was unremarkable for blood transfusion, mushroom

Table 2. Laboratory Data for the Five Patients With Autoimmune Hepatatis.

	Case 1	Case 2	Case 3	Case 4	Case 5
Total Bilirubin (mg/dl)	10	7.6	10	3.3	9
Total Protein (g/dl)	9.4	7.6	7.5	9	8.6
Albumin (g/dl)	3.4	2.2	3.5	4	3.9
IgG (mg/dl)	n.d.	3978	2705	2562	2830
SGOT (U/L)	1660	429	474	350	445
SGPT (U/L)	1070	197	325	466	171
GGT (U/L)	46	81	162	151	67
Anti-smooth muscle antibody	1:40	1:640	1:2560	1:2500	1:20
Anti-mitochrondrial antibody	1:20	Neg.	1:20	1:2560	Neg.
Anti-nuclear antibody	1:320	1:160	Neg.	1:640	Neg.
Anti-thyroid	N/D	Neg.	1:185	Neg.	1:169
Anti-liver kidney microsomal antibody	N/D	Neg.	Neg.	Neg.	Neg.
Anti-nuclear cytoplasmatic antibody	N/D	P - 1:2860	N/D	P - 1:160	Neg.
A-sialoglycoprotein	N/D	Neg.	N/D	Neg.	Neg.

poisoning, or contact with subject with hepatitis. Except for amoxycillin, she had not taken any medication. She looked sick and positive findings included deep icterus, abdominal fullness, and hepatomegaly of 1 cm below costal margin.

Her initial laboratory data (Table 1) showed an Hb - 11.2 g%, bilirubin - 9 mg%, total protein/ albumin - 8.1 g%/3.9 g%, and elevated liver enzymes. Viral screen for HBV, HAV, HCV, and CMV was negative. Ceruloplasmin, alpha-1-AT, and PT/PTT were within normal values. Autoimmune serum antibodies including anti-mitochondrial antibody, anti-nuclear-cytoplasmatic antibody, and anti-kidney-liver microsomal (KLM-1) were negative. Anti-smooth muscle antibody and anti-thyroid antibody tests were positive. Immunoglobulin profile showed increased IgG but normal IgA, IgM, IgD, and IgE levels.

Abdominal ultrasonography showed an enlarged, homogenous liver with normal pancreas and kidneys, and no ascites. Liver biopsy before initiation of therapy showed portal inflammation with piecemeal necrosis and bridging fibrosis (Table 2).

She was treated with prednisone (45 mg/day) and responded adequately within three weeks. Her recent lab results showed Hb 14.1 g%, total protein/albumin 7.8/4 g/dl, cholesterol 283 mg/dl, alk. phosp. 254 u/l, LDH 488 u/l, total bilirubin 0.8 mg/dl, SGOT 61 u/l, and gamma-GT 80 u/l.

Discussion

Autoimmune hepatitis (AIH) is a rare disorder characterized by a wide spectrum of symptoms ranging from asymptomatic elevation of transaminases with hepatomegaly to severe and progressive liver disease. AIH is more commonly seen in young females (4) and is sometimes associated with other autoimmune disorders like Sjögren's syndrome, ulcerative colitis, systemic lupus erythematosus (SLE), diabetes mellitus, hemolytic anemia and thyroiditis (1,8).

The etiology of AIH is still unknown, and several reports have implicated viruses such as those of measles and hepatitis C (9,10). In this report, we described five patients (two male, three female) who acquired this disease at a young age (mean 14 yrs), and had a slow progression of their liver disease. All presented with prolonged jaundice and non-specific symptoms, including loss of appetite, abdominal pain, fatigue and nausea. Extensive search for a specific etiology was fruitless. Positive serum autoantibody levels and the response to steroid treatment established the diagnosis.

Autoimmune hepatitis is classified into three types (10). Type 1 is characterized by high levels of serum anti-smooth muscle antibodies (4), AIH Type 2 with high titers of anti-LKM antibodies (1,5,6), and Type 3 with positive anti-soluble liver antigen (7). Four of our patients had negative anti-LKM antibodies and are considered to be AIH type 1. Type 2 is less prevalent and seen more commonly in younger patients (1,5).

Type 2 is further subtyped into 2A and 2B, depending on the presence of anti-HCV and anti-GOR antibodies, respectively (10). AIH-type 2 is commonly associated with extrahepatic autoimmune disorders

such as vitiligo, glomerulonephritis, hemolytic anemia, diabetes mellitus and polyendocrinopathies (1). It presents more often with fulminant hepatic failure.

Recent data have suggested an association between chronic hepatitis C infection and Type 2 autoimmune hepatitis (10). This observation suggested HCV as the etiology of AIH. None of our patients had positive anti-HCV antibody tests.

Several autoantibodies have been suggested as a marker for AIH type 1 including: anti-neutrophil cytoplasmatic antibody (ANCA) (11), asialoglycoprotein receptor antibody (12), and anti-liver cytosol antibody (anti-LC1) (13). Three of our patients were checked for ANCA antibody level and two were found positive. Three of the patients who were measured for antibody to asialoglycoprotein receptor were negative. Although this data may support the diagnosis of AIH-type 1 in our patients, the specificity and sensitivity of these auto antibodies in children is still to be determined.

Corticosteroid therapy is effective in inducing clinical, biochemical and histological remission in most patients. Despite good compliance with therapy, deterioration will occur in up to 20% of patients (14,15). Relapse after drug withdrawal occurs in up to 87% of those patients who do enter remission (16-18). Failure to induce permanent remission may result in cirrhosis, portal hypertension and liver failure. An immunosuppressive drug, i.e. Azathioprine, is often used in children who do not enter remission or who cannot continue steroid treatment due to severe side effects.

All five of our patients were started on Prednisone, but three (60%) were switched to azathioprine five months to one year later. The dose of steroid was tapered successfully in the other two. One patient who was non-compliant with medications developed liver failure three years after the diagnosis and has had an orthotopic liver transplantation.

The aim of the therapy is to keep patients asymptomatic with minimal hepatocellular damage (ALT < X2 of normal). Failure to achieve remission within four years and positive HLA A1, B2 tests are associated with poor prognosis. Patients who do not respond will benefit from liver transplantation. The five-year survival rate after orthotopic liver transplantation is 92% (19).

Conclusion

The five patients we treated had developed AIH in late childhood, and four responded to steroid and immunosuppressive drugs. One received liver transplantation following non-compliance with medications.

Although autoimmune hepatitis is rare in young children, negative search for viral, metabolic, or drug etiology should alert the physician to this diagnosis. Early diagnosis and treatment decrease morbidity and improve the clinical outcome.

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Injuries related to logging: Epidemiology, etiology and implications for prevention

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Abstract

This article describes our study of 36 male patients who were brought to Ruby Memorial Hospital in Morgantown for treatment of non-fatal logging-related injuries. The type and severity of their injuries is described, as well as the host, vehicular/mechanical and environmental factors contributing to the injuries. The suggestions of the patients on how to prevent their injuries are compared to existing OSHA standards.

Introduction

Logging is an important industry in West Virginia and is one of the five most dangerous industries in the United States (1). A recent study identified logging as having the highest fatality rate (129 per 100,000 workers) of all occupations (2), and the National Institute for Occupational Safety and Health (NIOSH) has reported that nearly 150 U.S. workers die yearly from logging injuries (3).

Although logging safety standards have been established for many years, logging activities continue to lead to serious injuries associated with varying degrees of disability as well as death (4). A number of studies have described logging-related injuries using data sources such as the National Traumatic Occupational Fatalities (NIOSH) surveillance system and the Census of Fatal Occupational Injuries (Bureau of Labor Statistics) (5,6,7). Most of these studies have focused on fatalities associated with logging injuries instead of the type and severity of non-fatal injuries, their outcomes and medical costs.

The goals of this research were to describe the population of non-fatally injured loggers who presented for care at Ruby Memorial Hospital in Morgantown over a two-year period. In addition, we describe the type and severity of injuries sustained, treatment required, length of disability, and the cost of treatment. The Haddon approach to injury analysis was applied to explore causative factors and to discuss potential injury prevention strategies (8).

Methods

Trauma registry records of patients injured while logging who presented at the level one trauma center at Ruby Memorial Hospital between January 1992 and December 1993 were reviewed. Injured patients who died prior to reaching Ruby Memorial and those who were treated and released from the Emergency Department were excluded from the study.

A logging-related injury was defined as any injury associated with commercial harvesting of trees, including felling (cutting down of trees), limbering (cutting limbs off a felled tree), skidder operating, and loading of logs onto trucks for transportation. Both self-employed loggers and those working for larger companies were included.

Data collected from the trauma register included age, gender, work-relatedness, ICD-9 E-code for external cause of injury, Glascow Coma Scale (GCS), Trauma Score (TS), Injury Severity Score (ISS), ICD-9 N-code for diagnosis, length of stay and procedures performed.

Telephone interviews were conducted on all patients to confirm the accuracy of data and to obtain further information concerning etiologic factors which led to the injury and to determine the length of disability. During the interview, each patient was asked to describe the circumstances leading up to the actual injury event and how it could have been prevented.

Descriptive analysis of the data was performed. Continuous variables were reported as means and categorical data were reported as counts (%). Prior to initiating this study, approval was obtained from the West Virginia University Institutional Review Board.

Results

A total of 36 patients who had presented to the trauma center at Ruby Memorial Hospital after being injured while logging were contacted for follow-up. The ICD-9 external cause of injury codes (E-codes) which were assigned to these patients varied and included E916 (accidentally struck by falling object causing blunt injury)

in 33 patients, E884.9 (fall from one level to another causing blunt injury) in two patients, and E920.8 (cut/pierce/other instrument causing penetrating injury) in one patient.

Host characteristics

The mean age of the men studied was 40 years (range, 22 to 80 years). Twenty-three (64%) claimed that they had been injured while working as a feller, limber, truck driver, or laborer. The other patients were hurt while cutting wood at home for their or their family/friends own use.

The average years of work experience in the logging industry was 10 years, but this time period ranged from as little as one day to as high as 30 years. Twelve (33%) men stated that they had not been using protective equipment such as a hard hat at the time of the injury.

Six patients claimed to have received some degree of job safety training consisting of educational pamphlets or first aid training. Six patients reported that after being injured, they received first aid from a co-worker who had been trained as an EMT.

Contributing factors

Most workers (32 or 88%) were injured between 8 a.m. and 4 p.m., and the peak months for injuries were in the fall and spring (Table 1).

Thirty or 83% of the loggers felt that the cause of the logging injury was related to human factors such as failure to follow standard procedure, incorrect operation of equipment, failure to evaluate the environment for hazards, and inattention. Several men were under the impression that their injury might have been prevented if they had just been able to "run faster" to avoid a falling tree. Three loggers who were injured in an area that had just experienced a major storm, stated that they felt the environment was usually hazardous due because many trees had fallen and others were left uprooted. In another incident, mechanical failure of equipment led to logs falling off a truck.

Table 1. Time And Seasonal Factors Of The 36 Logging Accidents.

Time of Day	Number of Respondents (n = 36)
12 a.m. - 8 a.m.	2
8:01 a.m. - 4 p.m.	32
4:01 p.m. - 11:59 p.m.	2
Month	
January	2
February	2
March	3
April	6
May	3
June	3
July	1
August	2
September	1
October	5
November	5
December	3

Table 2. Location Of Injuries In The 36 Loggers.

Characteristic	Number of Respondents (n = 36)
Head/Face	16
Skull fracture	3
Subdural hematoma	3
Extremities	12
Fractures	12
Nerve damage	1
Vertebral fractures	11
Spinal cord injury (paralysis)	4
Pelvic fractures	2

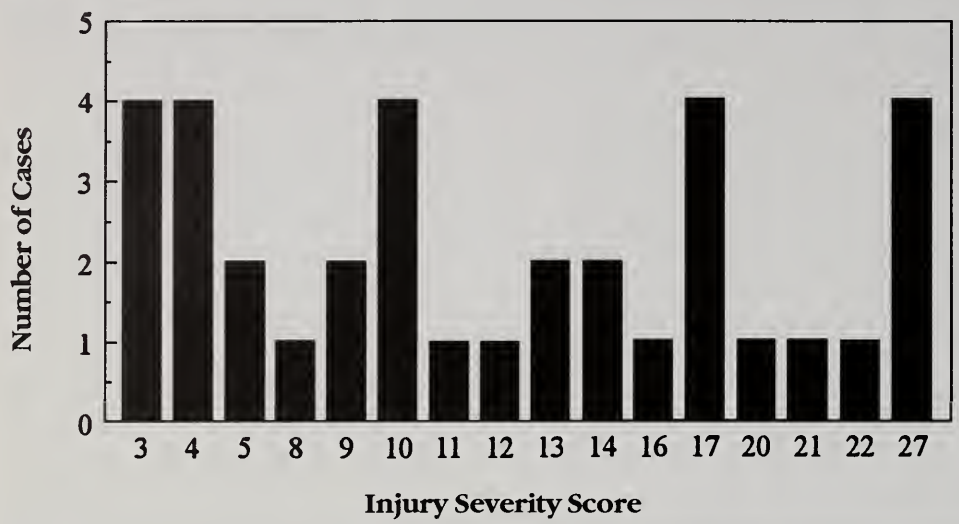
** The injury count > the sample size because several patients had multiple injuries.*

Outcomes

A wide variety of injuries were sustained by these men and most had more than one injury (Table 2). The most common injuries were head injuries in 16 of the 36 patients, extremity fractures in 12/36, vertebral fractures 11/36, chest injuries 8/36, and abdominal injuries in 4/36, and pelvic fractures in 2/36.

The average GCS was 14 (range 3 to 15), the average trauma score was 15 (range 8 to 16), and the average ISS was 14 (range, 3 to 27) (Figure 1). Tests performed included CT scans in 17 cases, aortography in six cases and cystourethrograms in six cases. Other diagnostic procedures performed included myelograms, ventriculostomies, sigmoidoscopies, bronchoscopies and echocardiograms.

Figure 1. Injury Severity Scores (ISS).



Fifteen (42%) patients required surgery. Nine (25%) required operative reduction and internal fixation of a fracture, five (14%) underwent spinal fusion, and one required craniotomy due to a skull fracture and intracranial injury. All patients were hospitalized with an average length of stay of 10 days (range 1 to 43 days). The patients spent an average of three days in the ICU (range 0 to 33 days), and hospital charges ranged from $850 to $136,900.

Three men were left permanently disabled and five were temporarily disabled. Four loggers were still unable to return to work at the time of this study, but their disability claims had not yet been settled.

Prevention strategies

The injured loggers suggested the following ways of preventing injuries:

- less pressure from the employer regarding speed of production;
- require at least two men to fell a tree;
- take more time to evaluate the environment and situation;
- stand back further before engaging winch to fall a cut tree;
- during debarking process, prohibit loading of logs onto debarker until operator is inside control booth; and
- provide onsite medical care and equipment including backboards and neck collars.

Discussion

Logging injuries are not uncommon in rural Appalachia. Although other mechanisms of traumatic injury such as motor vehicle crashes and falls are more common causes of work-related injury, logging injuries are associated with a higher rate of severe injury, disability, and fatality (5,8).

The high risk of fatal and non-fatal injuries among tree fellers is well known and in part due to the hazards of working around trees and equipment that weigh several hundred tons. In addition, since most logging activities take place in remote areas with steep and slippery terrain, these workers are at increased risk for injury and their access to prompt medical care is limited.

Like other diseases, injuries, including logging injuries, are preventable. However, in order to develop prevention strategies, detailed information concerning risk factors and events leading up to the injury are needed. In this study, we queried injured loggers concerning these items and have summarized these findings. Applying Haddon's injury model to these scenarios is a useful way to categorize major host, vehicle and environmental factors which have lead up to an injury event (8). Only a few logging injuries were due to mechanical and environmental factors and the majority of injuries were found to be a result of human factors such as lack of job safety training.

We found that all of the prevention strategies suggested by the victims in this study have also been established by OSHA (9). OSHA regulations call for safety programs at each worksite, the use of appropriate personal protective equipment (seat belts, helmets, boots), the evaluation of the environment for hazards (ice, dead limbs, spring poles), and the use of appropriate equipment.

From our review of these 36 logging incidents, we hypothesize that many, if not all, of the injuries sustained might have been prevented if the regulations had been instituted and enforced. In other words, new standards and regulations are not needed; rather, existing job safety strategies need to be implemented and enforced in order to be effective.

As physicians, we have a responsibility to incorporate prevention into our medical practices. NIOSH and OSHA may have resources and recommendations that could be disseminated into the arena of clinical medicine and be of benefit to injured victims.

The initial step towards controlling injuries is to collect and examine data on the patients that we care for. Data describing non-fatal logging injuries is not routinely available to organizations such as NIOSH and OSHA who base most of their research on fatality data. Such information on non-fatal injuries might be of value to organizations to expand their population base to include both fatal and non-fatal cases.

Several limitations of this study exist. First of all, the data presented here may not be representative of the rest of the nation as it reflects experience at a single level one trauma center in one geographic location. Actual logging operations may vary from state to state depending on the type of trees, terrain and other conditions specific to a particular location. In addition, this study is based on a relatively small number of cases and has excluded both non-hospitalized and fatal cases which may differ in the type of contributing factors and circumstances.

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 6.1 or earlier versions, or in ASCII. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced, and have page numbers in the right-hand corner of each page.

All manuscripts should include:

1. Title page.
2. An abstract of no more than 150 words.
3. Text.
4. Acknowledgements.
5. References in parentheses numbered consecutively. No more than 10 references will be published and then the following statement will appear: *Please contact author for the other references given in this manuscript.*
6. Tables.
7. Legends for illustrations.

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 1). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in solid black or pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Scientific Meeting of WVACP to again be held in conjunction with WVSMA Mid-Winter Conference

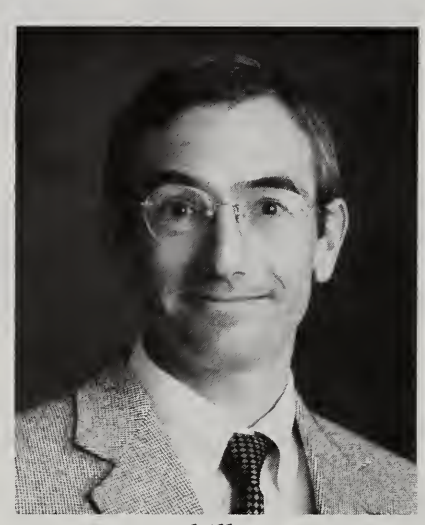
The 1997 Scientific Meeting of the West Virginia Chapter of the American College of Physicians will take place January 16-17 at the Holiday Inn - Charleston House, and will again be held in conjunction with the West Virginia State Medical Association's Mid-Winter Seminars and Scientific Conferences, January 16-19.

This year's meeting, chaired by **Shawn Chillag, M.D., F.A.C.P.**, will prove to be an important event with colleagues sharing the latest on issues dealing with ethics and clinical decision-making, national health care reform after the 1996 presidential election, and cost-effective care of peripheral vascular disease.

The excitement will begin Thursday evening at the Robert C. Byrd Health Sciences Center of WVU in Charleston with abstract presentations by ACP associates in concurrent sessions. Last year, 47 papers were delivered by residents in training at the four internal medicine programs in the state: West Virginia University, Charleston Area Medical Center, Marshall University, and Ohio Valley Medical Center. Again, presentations will be judged by ACP members, representing both academic and full-time practicing internists.

Friday morning's session will begin with a presentation by **Richard C. Scranton, M.D.**, the Eastern representative for the ACP Council of Associates. A legislative update will then be given by **Howard P. Shapiro, Ph.D.**, ACP vice president for public policy. He will discuss key issues involving health care reform, and the implications of the presidential and congressional elections.

Following Dr. Shapiro's address, **Christine K. Cassell, M.D., F.A.C.P.**, president of the ACP, will update the audience on news from the College.



Chillag

Her presentation will be followed by a series of ethical case presentations featuring audience interaction with a panel of physicians.

As in past years, Friday afternoon's session is a combined meeting, with participation open to participants of both the ACP and WVSMA meetings. This format provides an opportunity for West Virginia physicians from several practice disciplines to interact with each other, with a focus on internal medicine topics.

Dr. Cassell will lead off this session with a lecture entitled *"The Role of Physicians in Caring for Patients at the End of Life: New Developments on an Old Theme."* A professor and chairman of the Henry L. Schwartz Department of Geriatrics and Adult Development at Mount Sinai Medical Center in New York, Dr. Cassell is a renowned speaker in ethics and end of life issues. Her lecture will provide an excellent starting point for Saturday afternoon's WVSMA session on *"Caring for the Chronically Ill: New Challenges Resulting from Medicine's Successes,"* which was described in the last issue of the *Journal.*

The next speaker for this session will be **Mark Bates, M.D., F.A.C.C.**, who is a specialist in cardiology and peripheral vascular intervention with the Charleston Cardiology Group in Charleston. Dr. Bates is involved with several experimental protocols for stent placement and mechanical measures in coronary artery and peripheral vascular disease, and his lecture is entitled *"Methods of Treatment in the Cost-Effective Care of Peripheral Vascular Disease."*

After Dr. Bates talk, the residents who won honors for their abstracts on Thursday evening will present their papers and receive their awards. This session will then conclude after the presentation of this year's Laureate awards.

The American College of Physicians, with over 94,000 members, is the largest society of internists in the world. Founded in 1915, it is dedicated to providing educational and informational resources to the entire field of internal medicine and its subspecialties.

The West Virginia ACP Chapter is comprised of nearly 600 internists, including Associate members - - those still in residency training or awaiting membership appointment. Two-thirds of board-certified state internists are ACP members, nearly 40 percent of whom are subspecialists and the remainder general internists.

Over 100 state members have achieved the prestigious designation of Fellow of the ACP. This honor is awarded only to those members who are recognized by their peers for personal integrity, superior competance in internal medicine, professional accomplishments and demonstrated scholarship.

Physician/Public Session to discuss problems of communication between doctors, patients

The popular Physician/Public Session will again be offered during the WVSMA/WVACP Mid-Winter Seminars and Scientific Conferences at the Charleston House - Holiday Inn, and this year's subject will focus on "*Physician/Patient Communication - - How to Talk to Your Doctor.*"

Set for Friday, January 17 at 7 p.m., this session will feature **Michele Grinberg, J.D.**, counsel for the WVSMA; **Ronald H. Fishbein, M.D.**, associate professor of surgery at Johns Hopkins University; and **Alfred K. Pfister, M.D.**, a clinical professor of medicine at the West Virginia University School of Medicine, Charleston Division.

The public is encouraged to attend this free event. CME for physicians and CEU credit for RNs and LPNs is being offered through CAMC.

Bios on the panelists for this session begin below, and a registration form for the meeting appears on page 329.

For more information about the meeting, please phone the WVSMA at (304) 925-0342.

Grinberg

Fishbein

Pfister

Panelists highlighted

Ms. Grinberg is a Philadelphia native who graduated magna cum laude from Fairleigh Dickinson University in 1972 and received a master's degree in library science in 1976 from Simmons College.

Ms. Grinberg worked as a librarian for five years at West Virginia State College and then entered the West Virginia University College of Law, where she earned her doctor of jurisprudence degree in 1985. While in law school, she was editor-in-chief of the West Virginia Law Review.

For the past 10 years, Ms. Grinberg has practiced law with an emphasis in the areas of health care, professional liability, insurance coverage claims and civil rights. As a partner with Flaherty, Sensabaugh and Bonasso in Charleston, she has worked closely with the WVSMA staff for the past five years.

A member of the American Bar Association, the West Virginia State Bar, the Defense Trial Counsel of West Virginia and the National Health Lawyers Association, Ms. Grinberg was the first person to chair the West Virginia State Bar's Committee on Citzenship and Law Related Education. She is a board member of the United Way of the Kanawha Valley.

Dr. Fishbein graduated from Yale Medical School in 1957. He completed his internship with the Department of Surgery at Grace - New Haven Community Hospital in New Haven, Conn., and then did his residency with the Department of Surgery at Baltimore City Hospitals in Baltimore, Md.

After his residency, Dr. Fishbein served as a captain at Kimbrough Army Hospital at Fort George G. Meade, Md., for two years. During this time, he also assisted with the Department of Defense's Bioastronaautic Task Force for Project Gemini Support at Brooks Air Force Base in San Antonio.

In 1965, Dr. Fishbein became a surgeon at The Johns Hopkins Hospital, and an attending surgeon at Greater Baltimore Medical Center and Sinai Hospital of Baltimore. Dr. Fishbein still holds these three hospital appointments, as well as serves as an associate professor of surgery at Johns Hopkins University.

A diplomate of the American Board of Surgery, Dr. Fishbein is a member of numerous medical organizations including the American College of Surgeons, the Maryland Chapter of the Crohn's & Colitis Foundation of America, and the Maryland Academy of Science. In 1994, he received the Premier Physician Award of the Crohn's & Colitis Foundation.

Dr. Pfister received his M.D. degree from George Washington University in 1962. He interned at North Carolina Baptist Hospital, completed a residency at Charleston Memorial Hospital (now CAMC) in Charleston in 1968, and then a fellowship in infectious diseases at the University of Colorado.

Since his fellowship, Dr. Pfister has been practicing internal medicine in Charleston. He is also a clinical professor of medicine at the West Virginia University School of Medicine, Charleston Division.

During his career, Dr. Pfister has received many honors, including the Laureate Award from the West Virginia Chapter of the American College of Physicians and being named Clinician of the Year at CAMC. He is a former president of the West Virginia Society of Internal Medicine and the West Virginia Kidney Foundation.

Controversies Session to discuss issues about carotid endarterectomy, attention disorders

The Second Session at this year's WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences will be devoted to *"Controversies in Medicine,"* specifically focusing on issues surrounding carotid endarterectomy and attention deficit disorders.

Scheduled to begin on Saturday, January 18 at 9 a.m., this session will start with a lecture entitled *"Carotid Endarterectomy in Asymptomatic Patients"* by **Howard Kaufman, M.D.**, professor and chairman of the Department of Neurosurgery at the West Virginia University School of Medicine in Morgantown. Following Dr. Kaufman's talk, **Eugene Oddone, M.D.**, assistant professor of medicine in the Department of Medicine at Duke University Medical Center, will present his views on this subject in a lecture entitled *"Carotid Endarterectomy for Asymptomatic Patients Caveat Emptor."*

After a break, the second portion of this session will begin with a lecture by Charleston pediatrician **Mark Ayoubi, M.D., F.A.A.P.**, who will discuss *"Attention Disorder: A Pediatrician's Prospective."* His fellow panelist for this topic will be **Margaret Jaynes, M.D.**, an assistant professor of pediatric neurology at the WVU School of Medicine in Morgantown, who will speak on *"The Rational Use of Psychostimulants in Attention Deficit Disorders."*

Brief bios on these four speakers begins below and more details about the WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences can be obtained by phoning the WVSMA at (304) 925-0342.

Kaufman

Oddone

Ayoubi

Jaynes

Panelists highlighted

Dr. Kaufman received his medical degree from the Columbia University College of Physicians and Surgeons in New York City in 1966. After completing a surgical internship at the University of Minnesota Hospital in Minneapolis, Dr. Kaufman was a fellow at the National Hospital for Nervous Diseases in London from 1967-68.

Following his fellowship, Dr. Kaufman returned to the United States to accept a military assignment as a clinical associate in surgical neurology at the National Institute of Neurological Disease and Stroke at the NIH in Bethesda, Md. He held this post for two years and then continued his postgraduate studies at the Neurological Institute of New York at Columbia Presbyterian Medical Center in New York, where he completed a four-year residency in neurological surgery.

In 1974, Dr. Kaufman accepted a position as an assistant professor of neurosurgery at the University of Arizona at Tucson. He relocated the next year to Houston to become an assistant professor of neurosurgery at the University of Texas Medical School. Promoted to associate professor status in 1979, Dr. Kaufman also assumed additional teaching responsibilities as a clinical assistant professor in the Division of Neurosurgery at the Galveston branch of UT.

Four years later, Dr. Kaufman moved to West Virginia to become a professor and associate chairman of the Department of Neurosurgery at the WVU School of Medicine. In 1986, he was elevated to his current role as professor and chairman of the department.

Dr. Oddone graduated from the University of Colorado School of Medicine in 1985 with honors. He interned at the Duke University Medical Center in Durham from 1985-88, and was then awarded an A.W. Mellon Fellowship in clinical epidemiology at Duke for two years.

During his fellowship, Dr. Oddone served as chief medical resident at Duke and he accepted one of his current posts as a research associate at the Center for Health Services Research in Primary Care at the VA Hospital in Durham. In addition, from 1989-92, Dr. Oddone was a research associate for the Center for the Center for Health Policy & Research at Duke and he earned a master of health sciences in biostatistics degree.

Since 1991, Dr. Oddone has been an assistant professor of medicine at Duke. He also still holds his position as a research associate at the Center for Health Services Research in Primary Care at the VA Hospital in Durham, and he is research associate at the Center for Health Policy and Research at Duke.

In 1994, Dr. Oddone received the Eugene A. Stead Jr. Award For Excellence in Teaching from the house staff in the Department of Medicine at Duke. Board certified by the American Board of Internal Medicine, Dr. Oddone is currently the principal investigator of a study comparing the medical care given to HIV-infected patients by generalists and specialists at two clinics at Duke.

Dr. Ayoubi was born in Damascus, Syria and received his medical degree from the Damascus University School of Medicine in 1970.

After receiving his M.D. degree, Dr. Ayoubi came to the U.S. for a pediatric rotating internship at Uniontown Hospital in Uniontown, Pa. He then completed a pediatric residency at the WVU School of Medicine in June 1973, and moved to Charleston to serve as chief resident in neonatal/pediatric critical care at CAMC.

Since 1974, Dr. Ayoubi has been in private practice in Charleston as a pediatrician specializing in critical care in early childhood, and in developmental/behavioral pediatrics in later childhood. He is a clinical associate professor of pediatrics at the WVU School of Medicine, Charleston Division, and a clinical assistant professor of pediatrics at the Marshall University School of Medicine in Huntington.

A founding member of the Kanawha Chapter of the Epilepsy Foundation of America, Dr. Ayoubi is also a founding member and advisor of the Attention Deficit Disorder Information Network Support Group of Kanawha Valley. He is medical director for the Myelodysplasia Clinic for the West Virginia Handicapped Children's Services, and is a member and chairman of the Kanawha County Board of Education Medical Advisory Committee.

A fellow of the American Academy of Pediatrics, Dr. Ayoubi has served as as a peer reviewer for the West Virginia Medical Institute since 1988. He is also a member of the board of directors and Finance Committee for Carepoint Physicians, Inc., and a member of the Medical Advisory Board for Carelink.

Dr. Jaynes received a bachelor of arts in psychobiology at WVU in 1975, and then received a master of arts in communication disorders from Northwestern University in 1976.

From 1977-78, Dr. Jaynes worked as an itinerant learning disabilities instructor for Marion County School in Fairmont. In 1975, Dr. Jaynes accepted a new post with Marion County Schools as an individualized education plan specialist.

Dr. Jaynes worked for the school system until 1987, when she enrolled in medical school at WVU. After she graduated in 1991, Dr. Jaynes remained at WVU to complete residencies in pediatrics and in pediatric neurology, and then accept her current role as an assistant professor of pediatric neurology.

Dr. Jaynes is a member of the American Academy of Neurology, the Southern Pediatric Neurology Society, Child Neurology Society and the National Attention Deficit Disorder Association.

Justice Margaret Workman to be guest speaker for Lunch & Learn on family violence issues

"Family Violence and the Legal System" is the title of this year's Lunch & Learn program which will be presented at noon on Saturday, January 18 during the WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences in Charleston.

The special guest speaker for this event will be **Justice Margaret L. Workman** of the West Virginia Supreme Court of Appeals. Joining Justice Workman will be panelists **James D. Helsley, M.D.,** WVSMA Council chairman, and **Barbara Baxter, J.D.,** an assistant attorney general assigned to the Bureau of Social Services of the Department of Health and Human Resources. **Daniel S. Foster, M.D.**, chairman of the Mid-Winter Program Committee, will serve as moderator.

A registration form for this year's meeting appears on page 329. For more information, phone the WVSMA at (304) 925-0342.

Workman

Helsley

Panelists highlighted

Justice Workman of Charleston was elected to the West Virginia Supreme Court of Appeals in November 1988, becoming the first woman ever elected to a statewide office in West Virginia.

Throughout her judicial career, Justice Workman has been an advocate for children's interests, and has authored a number of significant cases developing the law on children's rights. Her opinions have mandated that abuse and neglect cases be given the highest priority in the judicial system. These opinions have formed the basis for the creation of a case tracking system for abuse and neglect complaints; enunciated the right of children to continued association with siblings and other persons with whom they have formed significant relationships; strengthened a child's right to support and an establishment of paternity; and made the failure to pay child support a tortious act for purposes of interstate collection under the long-arm statute.

(Continued on next page)

Lunch & Learn

(Continued from previous page)

In 1993, Justice Workman received the Excellence in Criminal Justice Award of the West Virginia Prosecuting Attorneys Association for her work on behalf of children, and was named the outstanding woman in government in the Celebrate Women Award for Government and Public Service. In addition, she received the 1995 Susan B. Anthony Award.

Prior to taking the bench, Justice Workman was in private practice in Charleston, served as a law clerk for the 13th Judicial Circuit, and was assistant counsel to the majority of the U.S. Senate Public Works Comittee. She was educated at WVU and the WVU College of Law.

Dr. Helsley is an associate professor of medicine at the WVU School of Medicine in Morgantown, who also practices family medicine and geriatrics. He has become very interested in issues relating to family violence since he served as moderator for last year's Lunch & Learn program *"Anatomy of Domestic Violence"* at the WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences.

A member of the WVSMA since 1981, Dr. Helsley served as WVSMA president from 1995-96 and currently is Council chairman. He is a diplomate of the National Board of Medical Examiners and the American Board of Family Practice, and is also a fellow of the AAFP.

Ms. Baxter was the first woman president of the WV State Bar, and was the first woman Chair of the Board of Governors of the WV State Bar.

Since 1995, Ms. Baxter has been an assistant attorney general for the Bureau of Social Services of the Department of Health and Human Resources. In this role, she works mainly with child protective services and services to juveniles who are in DHHR custody due to delinquency. Prior to this, she was a staff attorney for a rural legal services program in northern West Virginia for seven years where she often assisted women and children who were in family situations involving violence and abuse.

"Stump the Audience" program again planned for Fourth Session

A variety of fascinating lectures and presentations are scheduled to take place during the Fourth Session *"Potpourri of Topics"* on Sunday, January 19 at 9 a.m. during the WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences in Charleston at the Charleston House - Holiday Inn.

This session will begin with a lecture entitled *"Health and History: The Illnesses of World Leaders"* by **Robert D. Crooks, M.D.**, a retired Parkersburg pediatrician who is a noted local historian. In his lecture, Dr. Crooks will discuss the health problems of Franklin Roosevelt, Woodrow Wilson, King George III, Napoleon, Lenin, Hindenburg, Czar Nicholas, Winston Churchill and Hitler.

Dr. Crooks has had a lifelong interest in history and is a charter member of the Wood County Historic Landmarks Commission and was a member of the West Virginia Commission on Archives and History. Since he retired, Dr. Crooks has devoted himself to lecturing and writing about topics pertaining to medical history and pediatrics. An award-winning artist, Dr. Crooks has become known for his oil paintings of local historic inns, schools and houses.

After Dr. Crooks' presentation, **Sandra Y. Elliott, M.D.**, an associate professor of medicine at the WVU School of Medicine, Charleston Division, will lecture on the topic of *"Mad Cow Disease."* Dr. Elliott is in private practice with Infectious Disease Associates in Charleston and serves as vice-chair of CAMC's Department of Medicine.

Following a break, the Fourth Session will reconvene with the *"Stump the Audience"* segment which was so popular at last year's meeting. This presentation will be facilitated by **Warren Point, M.D.**, professor emeritus of the WVU School of Medicine, Charleston Division, and **Maurice A. Mufson, M.D.**, professor and chairman of the Marshall University School of Medicine. Dr. Point is a master and a former governor of the ACP, and Dr. Mufson received the WVACP's Laureate Award in 1994.

Crooks

Elliott

Point

Mufson

Three special guests will be presenting cases for Stump the Audience. The first will be **Rashida A. Khakoo, M.D.**, a professor of medicine at the WVU School of Medicine in Morgantown who also received the WVACP's Laureate Award in 1994. The next presenter will be **Albert K. Pfister, M.D.**, a clinical professor of medicine at the WVU School of Medicine, Charleston Division, who is also a former Laureate Award winner. In addition, Dr. Pfister will be one of the speakers for the Physician/ Public Session *(See page 325.)* The third guest will be **Charles E. Turner, M.D.**, a fellow of the ACP who served as president of the WVSMA from 1986-87.

Please see the opposite page for registration information.

REMINDER

The WVSMA/WV-ACP Mid-Winter Seminars and Scientific Conferences are coming soon!

Watch for Pre-conference Seminars to be announced

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- **Physician/Public Session** - "Physician/Patient Communication: How to Talk to Your Doctor"
- **Second Scientific Session** - "Controversies in Medicine"
- **Lunch and Learn** - "Family Violence and the Legal System"
- **Third Scientific Session** - "Caring for the Chronically Ill: New Challenges Resulting from Medicine's Successes"
- **Fourth Scientific Session** - "Potpourri of Topics"
- **MDTV Demonstration** - offered again due to popular demand

1997 Mid-Winter Seminars and Scientific Conferences

January 16-19, 1997

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Lunch & Learn	**(Saturday, Jan. 18)**		
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If you have any questions regarding the conference, please contact our office staff at (800) 257-4747 or (304) 925-0342.

If paying by check, please send registration form and check to:

West Virginia State Medical Association
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Charleston, WV 25364

CME & Special Events

Charleston Area Medical Center - Charleston

January 16
"Sub-Arachnoid Hemorrhage: Diffusing the Bomb," John H. Schmidt III, M.D., noon (Teleconference)

February 3-5
"Cardiovascular Conference at Snowshoe," sponsored by American College of Cardiology in cooperation with CAMC, Mountain Lodge Conference Center, Snowshoe, WV

February 6-7
"Pediatric Advanced Life Support," CAMC Education and Training Center

February 6
"Suicide Risk Assessment and Intervention," Tom Ellis, Psy.D., noon (Teleconference)

February 20
"Facilitating an Effective Breast Feeding Program in the Early Weeks," Mother/Baby Unit, noon (Teleconference)

Marshall Univ. School of Medicine - Huntington

March 4
"Research Day: Opening Day," Rochelle Hirschhorn, M.D., professor of medicine, chief of the Sect. of Geriatrics, NY School of Medicine, MU Student Center

March 5
"Research Day," Gateway Holiday Inn

March 14
"Nursing Home Care Update 1997," Sam Kidder, HCFA, Glade Springs Resort, Glade Springs, WV

Robert C. Byrd HSC of WVU - Morgantown

March 7-8
"Urology Update 1997," sponsored by WVU Dept. of Urology

April 10-12
"AIDS in West Virginia," Days Inn, Flatwoods

May 16
"WVNEC Ethics Conference"

WV State Medical Association - Charleston

January 8
"Advanced CPT Coding," 9 a.m. - 4 p.m., Ramada Inn, Morgantown

January 9
"ICD-9 Coding," 9 a.m. - 4 p.m., Ramada Inn, Morgantown

January 16-19
"WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences," Charleston House - Holiday Inn, Charleston

January 18
WVSMA Medical Student Section's Annual Meeting, Charleston House - Holiday Inn, Charleston

Area Outreach Programs

Sponsored by CAMC● & WVU♦

January 15
●"Substance Abuse Management in the ER," speaker TBA, Man Appalachian Hospital, 6 p.m.

January 21
♦"Compartmental Syndrome," David Hubbard, M.D., Camden-Clark Memorial Hospital, Parkersburg, noon

January 24
●"Neonatal Deaths: When Things Don't Go as You Planned," Marlene Moses, C.S.W., Man Appalachian Regional Hospital, 9 a.m.

Poetry Corner

Colonoscopy

My doctor said it had to be;
Another colonoscopy.
I'd had a polyp years before,
And so by now there might be more.
We then agreed upon a date,
Knowing that I should not wait.
Too often things are found too late,
And then you're really testing fate.
I went to the Consultant's place
To learn details of what I'd face.
It was the nurse who spoke with me
And gave details on what would be;
The things I could and could not do
To make sure that the doctor's view
Would be as clear as possible
(you can't see if the colon's full.)
Now if there's more you want to know,
Here's the whole scenario:
The prep begins the day before;
Liquids only, nothing more;
Not so bad, just drink a lot
Of liquids clear until you've got
Nothing left inside to pass
Except clear liquid (and some gas).
Then you take a pill or two.
Relax, the fun's ahead of you.
You try to sleep despite the cramps
That make you think you ate some ramps!
You soon go to the OPD.
The staff there plug in an I.V.
You're ready now, but have to wait
For Dr. X who's often late.
You're not the only case today
So there is often some delay.
Eventually he does appear
Prepared to look into your "rear."
He adds a drug to your I.V.
To help your test to be pain-free.
He then proceeds with skillful hands
While you explore some "la-la lands."
You wake up in another place
And see again your doctor's face.
You listen to him briefly tell
That all looked fine - - that you are well.
You return home - - you feel just great
Resolved that next time you'll not wait
When your physician wants a test;
For you now know that "Doc" knows best.

Bill Wallace, M.D.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Rural Health Awards presented in October

The fourth annual Governor's Rural Health Awards were presented at the West Virginia Rural Health Conference, which was held in Charleston from October 29-30.

This year's recipients included: Daniel B. Doyle, M.D., of Scarbro for Outstanding Rural Health Practitioner; Hilda R. Heady, of Morgantown for Outstanding Rural Health Achievement; the Tug River Health Association, Inc.'s Adolescent Pregnancy Prevention Project for Outstanding Rural Health Program; and the Northern Greenbrier Ambulance Service, Inc., for Outstanding Rural Health Community Project.

Dr. Doyle currently serves as medical director for a number of health care centers and programs in rural Fayette County. In 1978, he established the New River Health Association, Inc. in Scarbro to provide needed clinical health services to the area, as well as to offer a variety of programs to address specific health needs of the area.

Dr. Doyle has been a leader in state and local efforts to provide quality health education experiences for students in an effort to recruit health care professionals to underserved areas of West Virginia. He has developed manuals and electronic linkages for students and clinicians across the state, and as an instructor, consistently shows students how to practice preventive care as part of a team, in a holistic manner.

Ms. Heady came to West Virginia as a VISTA volunteer in 1968, and has since worked endlessly to improve the quality and access of health care for people across the state.

Working at Preston Memorial Hospital from 1981 to 1992, Heady served first as the director of the facility's Birthing Center, and then as the hospital's administrator. During her administration, the facility went from a $730,000 loss in 1987 to a $408,000 profit in 1992.

She currently serves as the associate vice president for rural health at West Virginia University and was instrumental in structuring the school's first rural rotations for primary care residents.

Since 1987, the Tug River Health Association has worked with the McDowell County Board of Education to address the county's high rate of adolescent pregnancies. An important part of that process has been gaining community acceptance for and establishing an adolescent sexuality awareness curriculum and family planning services in the school system. The program has succeeded in improving student access to primary health care services, reducing the teen pregnancy/birth rates, increasing the utilization of family planning services for adolescents and improving the knowledge and awareness of the issue.

The Northern Greenbrier Ambulance Service is a non-profit organization made up of 24 volunteer members, including two paramedics, five EMTs, and numerous drivers and aides. The group serves 2,500 people, making approximately 200 to 210 calls a year, with the average call coming from nearly 20 miles away from the nearest hospital facility. The group also partners with local elementary schools and takes part in local efforts to teach injury prevention and first aid to school children and community members.

The Governor's Rural Health Awards were established in 1993 to honor people and programs addressing health care issues and needs unique to rural West Virginia.

1995 Provisional Statistics Released

According to the 1995 West Virginia Provisional Vital Statistics Report, the state's population has continued to grow for the fifth straight year.

Compiled annually by the Bureau's Office of Epidemiology and Health Promotion, the report states that West Virginia's population in 1995 was 1,828,000, an increase from 1990 of approximately 1.9%, or slightly more than 34,500 people. This increase has reversed the decline occurring in the state between 1980 and 1990. Most of the population increase was due to people moving to West Virginia from other states.

The total number of births in the state decreased in 1995 to 20,950, down from 21,360 in 1994. While the number of births to teen mothers dropped to 3,594 from 3,721 in 1994, births to teens comprised 17.2% of all births in West Virginia in 1995.

There were 19,856 deaths in West Virginia in 1995, down from 19,945 in 1994. West Virginia's death rate remained at the 1994 rate of 10.9 deaths per 1,000 population, but the state's death rate still stayed higher than the national rate of 8.8. Heart disease and cancer remained the leading causes of death in the state, accounting for 34.2% and 23.6% of all deaths, respectively.

The number of deaths of infant under one year of age rose to 154 in 1995, from 131 in 1994. The 1995 state provisional infant mortality rate of 7.4 deaths per 1,000 live births was slightly below the national rate of 7.5, but up from the 1994 state rate of 6.1, the lowest infant mortality rate ever recorded in West Virginia. But the state continued on an overall downward trend from the rate of 16.9 recorded 20 years ago.

Final vital statistics for 1995 are expected to be released later this year.

CODING SEMINARS

ADVANCED CPT CODING FOR DOCTORS' OFFICES

January 8, 1997 9:00 a.m. - 4:00 p.m.

ICD-9 CODING FOR DOCTORS' OFFICES

January 9, 1997 9:00 a.m. - 4:00 p.m.

Location: Ramada Inn
I-68 & I-79
Morgantown, WV
(304) 296-3431

Presented by the:
West Virginia State Medical Association

In Association with:
AMA Financing & Practice Services, Inc.
A subsidiary of the American Medical Association

✂----------

CODING SEMINARS - *Registration Form*

Institution/Physician's Name: _____

Address: _____

City/State/Zip: _____

Registrant's Name: _____

Advanced CPT Coding for Doctors' Offices	$195 _____
ICD-9 Coding for Doctors' Offices	$195 _____
Total	_____

Payment **by credit card** _____Visa _____MasterCard

Card Number _____ Exp. Date _____

Signature _____ Date _____

If paying **by check**, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364
(O)304-925-0342 (F)304-925-0345

Robert C. Byrd Health Sciences Center of West Virginia University News

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of WVU, Communications Division, Morgantown

Medicare to support MDTV consultations

Brick

Vice President Al Gore and Donna Shalala, secretary of health and human services, recently announced that Mountaineer Doctor Television would be one of five telemedicine demonstration projects that will be eligible for Medicare reimbursement.

The announcement means that physicians who treat Medicare-eligible patients at one of the 15 sites in WVU's MDTV network will be able to bill the Medicare system.

"Telemedicine is moving from experiment to necessity," says Dr. James Brick, medical director of MDTV and a member of the Federal Communications Commission's Telecommunications and Health Care Advisory Committee. "This recognizes that health care services provided over MDTV and other telemedicine networks are valuable to patients."

The two-way interactive system allows specialists to examine patients at remote locations. Special tools allow physicians to hear patients' heartbeats and cameras let them look into their eyes and ears. The system is designed to take specialty care to medically underserved areas.

Dr. Brick noted that West Virginia's congressional delegation has been active in helping the federal government recognize the value of telemedicine, especially for rural areas.

Geriatrics chair created in honor of Dr. Morgan

Morgan

Layne

A Fairmont woman's wish to honor a WVU physician was fulfilled Oct. 4 when the WVU School of Medicine dedicated the Grace Kinney Mead Chair of Geriatrics in honor of Dr. David Zackquill Morgan.

Mead and her twin sister, Blanche Kinney, were patients of Dr. Morgan, and, when Mead died, she left a substantial sum to the School of Medicine to support a geriatrics program at WVU.

Dr. Morgan has been associated with the School of Medicine since he began medical studies there in 1948. He joined the faculty in 1961, and served in a number of posts until he retired in 1994. Dr. Morgan founded WVU's geriatric medicine program. He currently serves as an associate editor for the *West Virginia Medical Journal.*

The first holder of the honorary chair is Dr. Richard Layne, professor of medicine and associate director for clinical services of the WVU Center on Aging, who is also chief of the geriatrics section at WVU.

Moss receives Faith and Medicine Award

The WVU School of Medicine was one of six medical schools honored recently by the National Institute of Healthcare Research.

WVU was recognized for offering a course that trains future doctors to be aware of the linkage between religion and medicine, and to take note of patients' spiritual needs. This course is taught by Dr. Alvin C. Moss, director of the Center for Health Ethics and Law, who was presented the John Templeton Faith and Medicine Curricular Award.

The award includes includes a $10,000 grant.

DiBartolomeo to lead new national group

Dr. Anthony DiBartolomeo, associate dean for clinical affairs in the School of Medicine, has been elected the founding chair of the Group on Resident Affairs of the Association of American Medical Colleges at AAMC's fall meeting.

Dr. DiBartolomeo has served on the Section on Resident Education of the AAMC, and was chosen as chair-elect of this group last year. The group, formed by a number of AAMC members concerned with issues relating to the education of residents, became a formal part of AAMC at this year's meeting.

Resident education faces several important questions nationwide, including training issues related to managed care, working hours, and the quality of the educational experience for residents.

Wright named VP of management group

W. Robert Wright Jr., president and CEO of University Health Associates, has been named first vice president of the Medical Group Management Association (MGMA). He most recently served as the organization's second VP.

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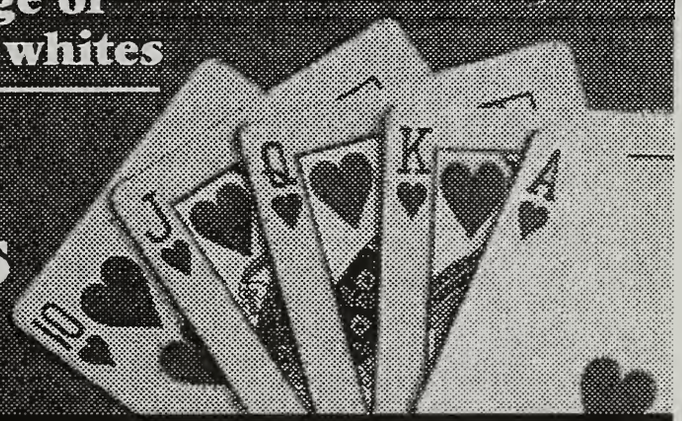

You can help make sure your African American cancer patients are dealt a fair hand. Studies show patients in phase III clinical trials conducted by the Radiation Therapy Oncology Group (RTOG) fare equally with respect to survival, regardless of race, once adjustments are made for time of entry and stage of disease at onset of treatment.

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To find out more about the Radiation Therapy Oncology Group and its clinical trials call 1-800-227-5463, extension 4912 or write: RTOG, 1891 Preston White Drive, Reston, VA 22091.

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Radiation Therapy Oncology Group
110 Market St.
Philadelphia, PA 19107

Marshall University School of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

New drug for stroke victims receiving final testing in Huntington

Tri-State residents are among the first in the nation to gain access to a new drug designed to reduce the effects of strokes, according to MU neurologist Dennis Briley.

Huntington is one of 100 centers worldwide involved in the final testing of the new drug Cerestat, said Dr. Briley, who heads the study in Huntington. Working with Dr. Briley are local neurologists, Dr. Carl McComas and Dr. Ronald Barebo.

Strokes strike half a million Americans a year and are the nation's leading cause of disability. The new drug works to minimize permanent damage and may allow stroke survivors to live more normal lives, Briley said.

"When you have a stroke, there is a central area that has irreversible damage, but around that is a borderline area that potentially can be saved with this new treatment," he said. The medication helps control chemical messengers in the brain that build up after a stroke to levels that poison and kill brain cells.

"We hope Cerestat will translate into more patients who can walk again, who can go home and care for themselves," Briley said. "Our preliminary testing is very promising."

To be eligible for the study, patients must be in the ER at Cabell Huntington Hospital or St. Mary's Hospital within 6 hours after stroke symptoms begin.

With Cerestat, as with other potential stroke fighters, early treatment is vital.

Med School earns accreditation to 2003

The School of Medicine has received continued accreditation to the year 2003 from the Liaison Committee on Medical Education.

The accreditation was granted based on the report of a survey team that visited the school in March. Surveyors praised the school's primary care successes, noting that graduates enter primary care practices "at rates that distinguish the school from most other medical schools in the U.S."

Other strengths cited by the visitors included the school's attention to the health care needs of the state, a faculty dedicated to providing outstanding education, and strong morale among students "who are poised, thoughtful, and rightfully proud of their school and who contribute to a positive learning environment."

The team praised Marshall's "outstanding" educational support services and noted the continued strong support by the school's three affiliated hospitals, Cabell Huntington Hospital, St. Mary's Hospital and the VA Medical Center.

Marshall Internet program semifinalist for national honors

Marshall's pioneering Interactive Patient, a teaching program that allows Internet users across the globe to test their medical knowledge, was a semifinalist for a National Information Infrastructure Award.

This program is a one-of-a-kind World Wide Web teaching tool that allows health professionals and other users to simulate a patient encounter. Through the magic of multimedia, users can interview the "cyberpatient," perform a physical exam, listen to heart and other sounds, order lab tests and view X-rays. They then can e-mail their diagnosis and treatment plan to MU, which sends them feedback. The program approved for CME credit.

The Interactive Patient can be found at:

http://medicus.marshall.edu/medicus.htm

The program was created by Kent Hayes of MU, a senior systems analyst, and Dr. Christoph Lehmann, who now is at Johns Hopkins University.

The program averages one or two awards each week, Hayes said, and has been featured in newspapers as far away as Australia, Germany and Great Britain. From a peak of 20,000 to 40,000 users a day when the program was chosen as the "Cool Site of the Day" on the Internet, the Interactive Patient has settled into a steady rhythm of 500 to 1,000 new users every day.

"If I see the server idle for two seconds twice a week, that's unusual," Hayes said.

The National Information Infrastructure Awards program was designed as a showcase for ideas and achievement more than a competition for excellence.

MU holds second Rural Health Fair

MU medical and nursing students gathered in downtown Huntington Oct. 10 for the School of Medicine's second annual Rural Health Fair.

Scheduled as part of National Primary Care Day, the fair introduced students to the rural learning opportunities available to them. Reps from 18 Rural Health Education Partnerships sites and subsites participated in the program.

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An Alliance Membership - - The Perfect Gift

The holiday season is here - - Are you looking for the perfect gift for your spouse? What about an Alliance membership?? Give your spouse a gift that is of benefit to your entire family.

Our members are diverse, professionally and culturally. Many of us work outside the home, either full or part time; many have very small children and are "stay-at-home moms or dads;" and some are back in school. In addition, we have members from many ethnic backgrounds who add a richness to our great organization. Many spouses have limited time to give to this group, but no matter what the level of involvement - - EVERY physician spouse is vital to the Alliance and to the West Virginia State Medical Association.

Our fundamental mission is this: to promote better health for the citizens of West Virginia, to support the medical profession and to offer understanding and friendship to all physician spouses.

In this ever changing world, no profession has felt this impact more than the practice of medicine. Some of you have lived through these changes, and some of you are just beginning to understand the complex array of factors that affect the way you practice. The Alliance has changed through the years, in name alone, from the Women's Auxiliary of the WVSMA, to the WVSMA Auxiliary, to the WVSMA Alliance. Through these changes, our focus has remained constant - - we are spouses dedicated to the health of West Virginians!

The Alliance has a strong place in today's world. As we approach the beginning of a new century, our country, our state and the national Alliances combine to form a medical family of great worth. WE ARE making a difference - - in the Legislature, in public health, in the support of research and in education via AMA-ERF, and most importantly, in the support of each other!

So, Doctors remember - - a membership to the West Virginia State Medical Association Alliance is the perfect gift for your spouse - - one that "keeps on giving" long after the holiday season. For more information, please contact me at (304) 242-2032 or the WVSMA at (304) 925-0342.

Happy Holiday From The WVSMA Alliance!!!

Kathy Fortunato
WVSMAA President-Elect

Med Student Section News

WVSMA-MSS Annual Meeting

January 18, 1997

Charleston House - Holiday Inn
Charleston, West Virginia

8 a.m. - 8:30 a.m.	**Registration** - Cobb Room
8:30 a.m. - 9 a.m.	**Welcome** - WVSMA President Ronald E. Cordell, MD WVSMA Executive Director George Rider WVSMA-MSS President Melissa Matulis
9 a.m. - 10 a.m.	**Special Session** - Chris Cogle, AMA-MSS Governing Council Chairman (tenative)
10 a.m. - 11 a.m.	**Special Session** - "Computer Based USMLE Testing, Parts 1,2,3" Eileen C. Catterson, MD
11 a.m. - 11:30 a.m.	**Break** - Exhibit Visitation
11:30 a.m. - 12:30 p.m.	**Luncheon** - Provided by the WVSMA-MSS
1 p.m. - 2 p.m.	**Media Communications Workshop** - Learn techniques to communicate more effectively with the media and the public
2 p.m. - 2:30 p.m.	**Break** - Exhibit Visitation
2:30 p.m. - 4 p.m.	**Business Meeting**

- Presidential Address
- Component Society Reports
- Election Nominations
- Committee Reports

WVSMA-MSS Annual Meeting Registration Form

Name_____

Address_____ Phone_____

City_____ State_____ Zip_____

Will you attend the luncheon? ____ Yes ____ No

Are you a WVSMA-MSS member? ____ Yes ____ No

Please fax or mail to Donna Webb at WVSMA-MSS, P.O. Box 4106, Charleston, WV 25364
Phone: (800) 257-4747 or 925-0342 Fax: (304) 925-0342

The AMA's Board Chair and General Counsel discuss how revised antitrust guidelines will benefit physicians

Photo by Ted Grudzinski

Kirk Johnson, JD and Nancy Dickey, MD

What are the major reforms in the new antitrust policy statements?

Dr. Dickey: The AMA was able to win three major concessions. First, the FTC and Justice Department have agreed to evaluate physician networks on a case-by-case basis instead of automatically ruling them "per se" illegal. Second, the restrictions on percentages of participating physicians have been relaxed, and third, the enforcement agencies have indicated a willingness to take a cooperative tone in reviewing physician networks.

How will physicians benefit from the new antitrust guidelines?

Mr. Johnson: The FTC and Justice Department have now written into their formal policies a test that physicians and their lawyers can rely upon. If you're in a competitive market, and you meet minimal joint venture requirements, you are unlikely to run into antitrust problems.

We will use these new policy statements to defend physicians and physician groups in this very competitive marketplace. They are a green light, rather than the red light, or the yellow caution light we have had for so long. Antitrust concerns will no longer be an obstacle to starting a network.

> "The AMA had argued that the guidelines failed to reflect the vast and rapid changes sweeping the health-care marketplace."
>
> *The Wall Street Journal August 29, 1996.*

What role did the Federation play in bringing about these important reforms?

Dr. Dickey: There's no doubt that this achievement, like so many of our accomplishments in the last couple of years, came about because of the huge role played by the Federation. It was their grassroots communications with their Congressmen and Senators that allowed the AMA to get the Hyde Bill out of the House Judiciary Committee and build a wall of support. Over 100,000 physicians, coordinated by the AMA's D.C. office, lodged their views consistently and relentlessly. We never could have done it without them.

Do you now expect more physicians to form networks of their own?

Dr. Dickey: I hope so. We as an organization need to be sure that we aggressively get the word out to those physicians who may have been sitting on the fence that now is the time to move forward and the AMA will be there to support them as they take the first steps.

How do you respond to critics who charge that the revised policy statements will promote anticompetitive behavior?

Dr. Dickey: It all comes down to the importance of a competitive marketplace. By definition, physician networks exist in communities that have other competitors in the marketplace. If the physicians attempted to establish an anticompetitive fee schedule, the managed care organization would simply contract with a different network, or put together its own group of physicians.

Mr. Johnson: Everybody gains when physician networks are encouraged. Patients gain, physicians gain, and overall we think the quality of care will be better, more efficient too.

Is passage of the Hyde Antitrust Reform Bill still necessary?

Dr. Dickey: We owe Cong. Hyde (R-IL), and all of those who supported H.R 2925, an immense debt of gratitude. There's no doubt in my mind that without this legislation, the antitrust reforms simply would not have happened. We will not continue to pursue passage of the Hyde Bill with the same energy because we have already achieved the steps we felt were absolutely imperative with these regulatory changes.

Interview by Wendy Sue Morphew

Obituaries

Robert James Clubb, M.D.

Dr. Robert James Clubb, 53, of Charleston, died October 12 at his home after a long illness.

Dr. Clubb was born in Clarksburg and received an A.B. degree at WVU in 1965 and his M.D. degree from Northwestern University in 1969. He interned in surgery at the University of Michigan in Ann Arbor and then completed a neurosurgery residency at the University of Minnesota, where he obtained a Ph.D. degree in neurosurgery.

A partner with Neurological Associates Inc. in Charleston, Dr. Clubb was on the staff of the National Naval Medical Center in Bethesda, Md. In addition, Dr. Clubb was a clinical professor of neurosurgery at the WVU School of Medicine, Charleston Division.

A WVSMA member since 1970, Dr. Clubb was also a member of the Neurological Surgeons, the American College of Surgeons, the AMA, the Congress of Neurological Surgeons, the Southern Neurological Society, the Southern Medical Society, the Kanawha Medical Society and the Charleston Rotary Club. He was a Navy veteran with 20 years of service who attained the rank of captain. Dr. Clubb was active in scouting and had earned the rank of Eagle Scout, and was a member of the Order of the Arrow.

Surviving: wife, Mary Paff Clubb; sons, Robert James Jr. and John David, both at home; parents, Melvin Russell and Wanza Frame Clubb of Clarksburg; sisters, Dr. Gretchen C. Haines of Jackson, Miss., Mary C. Lotshaw of Morgantown, Dr. Elizabeth A. Clubb of Baton Rouge, La.

The family suggests donations to the CAMC Foundation (Cancer Fund), 3200 MacCorkle Ave., Chas., WV 25304.

Harry Carrington Fleming, M.D.

Dr. Harry Carrington Fleming, 85, of Grafton, died September 26 at Grafton City Hospital.

Dr. Fleming was born in Grafton and graduated from WVU and received his M.D. degree from the University of Virginia School of Medicine. After interning at the University of Virginia Hospital, Dr. Fleming completed residencies at the NY Post Graduate School of Medicine Hospital and the Reconstruction Hospital in NY. He also did postgraduate studies at the Medical College of Virginia.

Dr. Fleming practiced medicine in Fairmont for over 40 years and was a former chief of the medical staff at Fairmont General Hospital, as well as a physician at Fairmont State College. In addition to being a WVSMA member, Dr. Fleming was a past president of the Marion County Medical Society, and was a member of Beta Theta Pi, Alpha Epsilon Delta, the pre-medical fraternity, Beta Phi Theta, Phi Beta Kappa and Alpha Omega Alpha.

A veteran of WWII, Dr. Fleming served with the U.S. Army Medical Corp from 1941-45. He was active in the China-Burma-India Theater and earned the rank of major.

Dr. Fleming was a member of the First Baptist Church of Fairmont. He is survived by his wife, Nell Drummond Fleming of Pruntytown; his son, Harry Carrington Fleming Jr. of Charleston; two daughters and sons-in-law, Patricia and Roger Cleavenger of Pruntytown; and Pamela and John Davidson of Wallingford, Pa.; one sister, Rosalyn Heironimus of Morgantown; four grandchildren, Stacy Beckman, Thomas Robert Taylor IV, William Todd Ice and Justin Davidson; one great-grandchild, Alexis Beckman; and one newphew, Dr. T.W. Heironimus III of Morgantown.

Willard Pushkin, M.D.

Dr. Willard Pushkin, 85, a legend in Charleston's medical circles, died at home on November 13 after a long battle with lung cancer.

A native of Charleston, Dr. Pushkin received his medical degree from the Medical College of Virginia in Richmond in 1939. He interned at Sinai Hospital of Baltimore and then completed his residency at Charleston General Hospital in 1941.

Dr. Pushkin had specialized in internal medicine and was a former chief of staff at CAMC, a member of the CAMC board and CAMC Foundation, and a clinical professor for the WVU School of Medicine, Charleston Division. He had closed his office in 1980, but continued to care for former patients and CAMC employees.

Dr. Pushkin had spent two years practicing in Israeli settlements in the late 1950s. He had been the physician at the Kibbutz Haogen in Israel. His love of that country continued until his death, his widow said.

Dr. Pushkin served with the U.S. Army Medical Corps from 1942-46, earning the rank of major.

Until his recent illness, Dr. Pushkin could be heard almost every Friday night conducting the early Sabbath services at B'Nai Jacob Synagogue. He was fluent in Yiddish, and considered an authority on Charleston's Jewish community. He established the Judah B. Pushkin Memorial Lecture Series of the CAMC Foundation to bring well-known medical ethics lecturers to Charleston, as well as the Judah B. Pushkin Scholarship Fund for the West Virginia Symphony Youth Orchestra.

Dr. Pushkin is also survived by his sons, Dr. Yaacov Rabi Pushkin of Norfolk, Va., Dr. Joshua Robert Pushkin of Denver, and David Michael Fineman of Berkeley, Calif.; daughter, Rebecca Tamar Pushkin of Morgantown; and sister, Dorothy Hark of Charleston.

The family requests donations to the Judah B. Pushkin Memorial Foundation, which benefits Hospice, at P.O. Box 2613, Charleston, W.Va., 25329.

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